

County of San Luis Obispo Drug & Alcohol Services

Documentation Guidelines

Effective January 2017

For reporting suspected inappropriate or non-standard documentation,
coding, billing or clinical issues practices:

You may report through your supervisory reporting structure

You may report to Compliance Officer: 781-4788 or katasseff@co.slo.ca.us

You may contact the anonymous, toll free hotline at (855) 326-9623

You may email the anonymous hotline at reportlineweb.com/sanluisobispo

OVERVIEW

San Luis Obispo County Behavioral Health Department Quality Support Team produces and periodically updates the *Documentation Guidelines* to serve as the official reference for all outpatient clinical documentation. This manual serves as guidance to promote excellent, accurate and timely documentation of the services we provide to our community. We strive to provide high quality care to our clients, and accurate documentation is a crucial step in the process of delivering excellent care.

A client's record should depict an integrated record of treatment and have a "flow" often referred to as "The Golden Thread".



- The documentation manual defines key concepts, explains documentation requirements, and provides examples of how to document various types of substance use disorder treatment services.
- All staff providing clinical services should refer to the manual whenever they need an answer to a documentation question. Inevitably, situations will arise when staff have questions not answered here – imagine the size of a manual that anticipated every contingency! In such cases, the Program Supervisor should be consulted. Quality Support Team staff are also available to address questions concerning documentation.
- Examples are illustrative and are not meant to replace clinical supervision or sound clinical judgment. Examples are not meant as “cut and paste”, one-size-fits-all solutions.
- The manual will be used for all client records regardless of payer source. Specialty programs within the SLO BHD may have unique documentation requirements (i.e. a grant funded program may have specified additional items to include in the record).

SOURCES OF INFORMATION

This *Documentation Guidelines* is to be used as a reference and includes information from the following sources: the California Code of Regulations (Title 22), the California Department of Health Care Service’s (DHCS) letters/notices, the SLO County Behavioral Health Department’s (SLOBHD) policies & procedures, and the contract between DHCS and SLOBHD. Additional information and guidance is gathered based on consultation between QST staff and our counterparts in other counties. This guideline document captures documentation requirements with SLOBHD’s implementation plan for the Drug Medi-Cal Organized Delivery System.

NAVIGATION TIPS – THIS SECTION IS UNDER CONSTRUCTION

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✧ Definition of Key Terms ✧

Electronic Health Record (EHR): information contained in the client EHR is considered confidential and is disclosed only to authorized persons in accordance with federal, state, and local laws, especially HIPAA and 42 CFR, Part 2.

Licensed Practitioner of the Healing Arts (LPHA): This group includes any professionally licensed staff (Psychologist/LMFT/LCSW/LPCC) or staff registered with a licensing board (registered MFTI/ASW/PCCI).

Certified Treatment Staff: This group includes professionally certified staff (CAADE, CATC, CAS, CCAPP), Counselors.

Single Accountable Individual (SAI): Primary Counselor/Therapist.

Community Based Organizations (CBO): Bryan's House, THMA, Aegis, FCNI, CAPSLO.

Client: An individual is considered to be an outpatient client when the individual gives informed consent for treatment (evidenced by signature) and has an expectation of privacy. Legally Responsible Persons may consent on behalf of clients who are minors or LPS conservatees. A client is assigned a medical record number.

Consent for Treatment: Prior to beginning outpatient services, each client and/or Legally Responsible Person must make an informed decision about the risks and benefits of treatment (including no treatment). The decision to participate in treatment is documented by obtaining the signature of each client (age 12 and older) on the BH Consent for Treatment in Anasazi. A Legally Responsible Person must sign on behalf of all minor clients who are not consenting for treatment on their own and for all LPS conservatees. Consent for treatment is valid from the date of signature until treatment ends or until revoked by the client/Legally Responsible Person. Services provided after informed consent for treatment has been obtained can be billed to an appropriate treatment plan. For more information about Minor Consent Services and signature requirements for minors, please refer to Appendix H.

“Planned” and “Unplanned” Services: Planned means included on the Treatment Plan.

Significant Support Person: A person who could have a significant role in the successful outcome of the treatment of the client (e.g. parents, siblings, sponsor legal guardian of a minor, legal representative of an adult, spouse, a person living in the same household).

✧ DAS Basic Staff Position Information ✧

Division Manager: Starlene Graber, PhD, LMFT is the DAS Division Manager. Star has been with the County of San Luis Obispo Drug and Alcohol Services for over thirty years. She holds a doctorate in psychology and is a Licensed Marriage and Family Therapist. She also possesses a Certified Clinical Supervisor certificate through CADAAC. She has expertise in service to adults, youth, and families with substance use disorders. All Program treatment clinic staff work under her direction.

Program Supervisor: Program Supervisor staff possesses a clinical license, such as Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, Licensed Professional Counselor, or Certified Clinical Supervisor (or equivalent) from an alcohol and drug certification program. They also possess specialized experience in alcohol and drug treatment programs including clinical evaluation, treatment planning, and individual and group counseling.

Clinical Supervisor: Clinical Supervisors assist both clinical and non-clinical treatment staff with individual or group supervision, education, and substance use disorder treatment training. Clinical Supervisors may provide supervision to staff seeking their BBS training hours towards licensure.

Assessment Coordinator: LPHAs who have been assigned to the Access Team, are lead workers for the clinic and can act in the absence of a Program Supervisor.

DAS Specialist: The Drug and Alcohol Specialist positions provide treatment services. Staff are LPHAs or Certified.

Specialists can be assigned to Counselor or Case Management roles.

Medical Staff: Any Physician, Registered Nurse, Licensed Vocational Nurse, or Licensed Psychiatric Technician.

DAS Worker Staff: The Drug and Alcohol Services Worker positions provide child care, transportation, drug testing services, case management, and other duties as assigned.

Intake Clerical Staff: Work with clients and Assessment Coordinators to enroll clients in programs and conduct walk-in intakes.

Administrative Assistant (AA): The Administrative staff provides reception, medical records maintenance, billing, financial assessments, outcomes, and client and programmatic evaluation efforts.

Health Information Technician (HIT) Staff: The duties of the HIT staff are to oversee the management and movement of both physical and electronic health records. The HIT team works closely with the quality assurance team to audit charts for compliance and to maximize billable services.

San Luis Obispo Drug and Alcohol Services comply with the confidentiality requirements of HIPAA and 42 CFR, Part 2. All staff are trained on confidentiality and required to sign a confidentiality statement prior to commencing employment.

✧ Utilization Review ✧

San Luis Obispo Drug and Alcohol Services has an active peer review and a separate Utilization Review program. Specific elements germane to substance use treatment services are as follows:

Each client is assigned a primary Specialist who is responsible for overseeing all components of the client's treatment. The primary Specialist is responsible for ensuring that the following activities occur:

- The treatment plan is developed within 30 days after admission.
- Required services are provided as clinically necessary and in accordance with Title 22 regulations, and that these services are accurately documented.
- Attendance and/or non-compliance issues are documented and discussed with the client.
- Progress or barriers in achieving treatment plan goals and objectives are assessed and documented on a continuous basis.
- The treatment plan is updated and reviewed at least every ninety days.
- All relevant documents (releases, correspondence, referrals, consent to treatment, etc.) are contained in the chart.
- Referrals are made and documented as they occur.
- Lack of progress in the current level of care necessitates a change in the treatment plan and may also include a change in the level of care provided to the individual.
- A discharge plan and discharge summary are developed.

All EHR reports are reviewed at least monthly by the Clinical or Program Supervisor to assure compliance with

DMC standards.

✧ Access Line ✧

Referrals to DMC-ODS services will come through five primary gates, one of which includes calls to the Behavioral Health Department Access Line/Managed Care. A call may result in an individual screening appointment being scheduled with an Assessment Coordinator in one of the four County-operated clinics.

Behavioral Health Service Request

If the phone call comes into the Behavioral Health Department Access Line (1-800-838-1831), the Managed Care Clinician fills out a Service Request form and schedules the individual to attend a walk-in clinic or schedules a screening appointment with the Assessment Coordinator at the desired clinic location. Information from the phone call is documented on the **BH Service Request**. The AA starts the **Demographic Form** and the Clinician completes it.

✧ Admission Paperwork ✧

An electronic health record, EHR, (chart) is established for each client when the treatment episode is opened. Client information is maintained and released in accordance with the requirements of HIPAA and 42 CFR, Part 2.

All records contain the following client demographic and identifying information; unique client identifier, date of birth, gender, race/ethnic background, address, telephone number, next of kin, emergency contact (if client is not living at home), consent for treatment, referral source and reason for referral, date and type of admission. This data, along with the CalOMS dataset, and all other data obtained in the intake and assessment process outlined below is maintained in the client EHR.

CONSENT FORMS

BH Consent for Treatment: Every client must read and sign Consent to Treatment prior to admission to the program. The consent to treatment discusses the mutual roles and responsibilities of the client and the program. All clients are given a copy of the Client Handbook at screening for Program services. Signature(s) on the BH Consent for Treatment must be obtained to document that the client/Legally Responsible Person understands and agrees to participate in treatment.

Notice of Privacy Practices: Every client must read that they received a copy of the Health Agency's Notice of Privacy Practices. The document is provided to the client in the Client Handbook.

HIPAA (BH Acknowledge HIPAA Notice): Every client must read and sign that they received a copy of HIPAA notices. The document is provided to the client in the Client Handbook.

Joint Medical Records Consent (SA Consent – Rel Conf Info-JR): Every client must read and sign the Joint Medical

Records Consent form. This form notifies the client that Drug & Alcohol Services, Mental Health, and other CBO's utilize a common chart (medical record).

Fee Agreement (SA Fee Agreement): Every client must sign the Fee Agreement. The fee agreement form states that Medi-Cal covers all treatment services in full as long as the client maintains Medi-Cal eligibility. Drug & Alcohol Services does not accept or bill private insurance. Fees are outlined based upon client income and household size. The

Debt Collection (SA Consent – Rel Conf Info-DC): Every client must read and sign the Debt Collection Release of Information. The Debt Collection form allows the Health Agency to disclose information to Probation or to other collection agency.

Release of Information: Depending upon the referral source, a Release of Information (ROI) may be necessary and will be reviewed with the client at admission. All ROI's expire in one calendar year and therefore require an annual update. The exception is the Criminal Justice ROI which is non-revocable and opened for a particular criminal case number. It remains best practice, however, to update this release annually.

General ROI (SA Consent – Release Conf Info): Utilized to specify a referral from another entity and/or to provide collaborative care for the client such as: Physician, Community Therapist, Recovery Residence, previous Residential Treatment provider, etc. Must be updated annually.

Criminal Justice ROI (Probation referred) (SA Consent – Rel Conf Info-CJ): Utilized to provide collaborative care with Probation, Courts, and Parole. Although this release is valid for the length of the **specific** criminal charge that created a referral for SUD treatment, it is best practice to update this release annually (see above).

Child Welfare Services ROI (CWS referred) (SA Consent – Rel Conf Info-CWS): Utilized to provide collaborative care with CWS. Must be updated annually.

ROI Quick Tips:

- All ROI's have to have an expiration date entered (one year from date of the form origination). If there is no expiration date entered, the form is invalid.
- ROI's cannot include blanks.
- If an ROI has expired, information cannot be exchanged until the client signs a new release. Therefore, treatment staff are encouraged to check releases frequently.
- If naming a Social Worker or Probation Officer on an ROI, write in "Assigned Social Worker" or "Assigned Probation Officer," instead of the specific workers name to plan for treatment team member changes.

Contracts for Specialty Programs: Specialty treatment programs such as Prop. 36, Detox, Medication Assisted Treatment, Deferred Entry of Judgement (DEJ), Intensive Outpatient Treatment (IOT), Perinatal Outpatient Extended Group (POEG), etc., have additional contract forms that are reviewed with the client at admission.

DEMOGRAPHIC

Clerical enters a demographic, which includes the client's contact information (name, address, phone number),

emergency contact, financial and employment information. In the event that this form needs to be updated, the Case Manager/Specialist provides the data to clerical staff to complete the update.

HEALTH QUESTIONNAIRE & PHYSICAL EXAM REFERRAL (CONSENT FOR THE EXCHANGE OF CONFIDENTIAL INFORMATION):

The Program's Medical Director is Daisy Ilano, M.D. is the County's Behavioral Health Medical Director. She is a licensed psychiatrist with the State of California. She is the on-site Medical Director for the County's Psychiatric Health Facility so that any clients with mental health issues that require hospitalization will be seen by Dr. Ilano or her designee. In addition, Dr. Ilano works closely with the local emergency room physicians to coordinate other general acute care that may be needed and has admission protocols in place. The role of the Program's Medical Director, or designee, is to establish, review and maintain medical policies and standards and to assure the quality of medical services provided to Program clients. This is accomplished through regular meetings with the Clinical Director, Program Nurse Practitioner, and other organized medical staff. The Medical Director exercises medical responsibility for client treatment through these staff conferences and their review and signature of the client's medical history and treatment plan.

Each Assessment Coordinator shall review the Health Questionnaire while in the presence of the client during the admission process (please see screening section of this document), noting any possible emergency medical services needed. San Luis Obispo County Drug and Alcohol Services employs a Nurse Practitioner who are available for consultation via cell phone. The Program's Medical Director is also available for consultation and for admission to the local hospitals or Psychiatric Health Facility (PHF) as needed. All emergency and urgent medical concerns need to be addressed immediately and documented in the BH Initial Screening assessment, progress note, or informational note.

The Health Questionnaire flows as follows:

Administrative Assistant to → Assessment Coordinator/Clinician → to Health Information Technician → to the Medical Director

In addition to the AOD history obtained through the screening process, the client will provide a complete self-report medical history using a standard Health Questionnaire form utilized by San Luis Obispo County Behavioral Health Department. In the interests of minimizing the spread of infectious disease, the medical history will be obtained as early as possible in the screening process. The Health Questionnaire is reviewed by Assessment Coordinator and discussed with the client to screen for infectious disease, mental health diagnosis, medications, suicide risk, as well as the need for withdrawal management and medication assisted treatment services, noting any possible emergency services needed.

The Medical Director, or designee, will review all completed medical history forms within 30 days of admission. In no case will the medical history be reviewed and approved later than 30 days after admission. If, in his or her opinion, physical and/or laboratory examination is warranted, the client will be referred to a local health provider or be conducted by the Nurse Practitioner or other Physician. Another option is to secure the client's most recent health physical information from the client's primary care provider. A **Physical Exam Referral** form (consent to secure records) is signed by the Client and a request for medical records is sent over to the client's primary care physician by the HIT. If the client does not have a primary care physician or if the client's physical was longer than 12 months ago, the primary Specialist will put this as a goal on the client's Treatment Plan to secure a health

physical as soon as possible.

CLIENT RIGHTS

As part of every admission process, the client is informed of the program's policy of non-discrimination, their rights as a client, grievance procedures, the appeal process for discharge, program rules and regulations, fee policy for DMC clients, and the right of access to their case file. The client is given a written copy of the aforementioned documents and the client rights statement is posted on program premises. All clients are given the Client Handbook which describes the various documents signed, program rules, and potential referral information.

Behavioral Health employs a Patient's Rights Advocate who has the ability to provide assistance to the client with filing appeals, expedited appeals and grievances.

✧ Medical Necessity Criteria for Outpatient & Intensive Outpatient Substance Use Disorder Treatment Services ✧

Medical necessity will be established in the screening and assessment processes outlined below. The appropriate DSM 5 diagnostic code will be identified in screening and assessment processes. Medical necessity must be established within 30 days of the client's admission to treatment date.

Medical necessity can be established by a Medical Director, licensed physician, or a LPHA. The review for medical necessity must be a face-to-face interaction.

MEDICAL NECESSITY

1. **Must have at least one diagnosis from the DSM 5 for Substance Related and Addictive Disorders (with the exception of tobacco use disorder and non-substance addictive disorders):**

The DSM 5 lists 11 criteria for Substance Use Disorders.

- A. A problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
 - 1. The substance is often taken in larger amounts or over a longer period than was intended.
 - 2. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
 - 3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
 - 4. Craving, or a strong desire or urge to use the substance.
 - 5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
 - 6. Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
 - 7. Important social, occupational, or recreational activities are given up or reduced because of use of the substance.
 - 8. Recurrent use of the substance in situations in which it is physically hazardous.
 - 9. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

10. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
 - b. A markedly diminished effect with continued use of the same amount of the substance.
11. Withdrawal, as manifested by either of the following:
 - a. The characteristic withdrawal syndrome for the substance (refer to criteria A and B of the criteria set for alcohol or other substances withdrawal).
 - b. The substance (or closely related substance, such as benzodiazepine for alcohol) is taken to relieve or avoid withdrawal symptoms.

2. Specify current severity of the substance use disorder:

Mild: Presence of 2-3 symptoms.

Moderate: Presence of 4-5 symptoms.

Severe: Presence of 6 or more symptoms.

3. Determine if there is a further specifier that should be noted:

In early remission: after full criteria for the substance use disorder were previously met, none of the criteria for the substance use disorder were met for at least 3 months but for less than 12 months (with the exception that “craving, or a strong desire to use substance” may still be met).

In sustained remission: after full criteria for the substance use disorder were previously met, none of the criteria for the substance use disorder have been met at any time during a period of 12 months or longer (with the exception that “craving, or a strong desire to use substance” may still be met).

In a controlled environment: This additional specifier is used if the individual is in an environment where access to alcohol or substances of abuse is restricted.

[Please click here to jump to Appendix D for SUD ICD 10 Included Codes](#)

[Please click here to jump to Appendix E Included SUD ICD 10 Remission Diagnosis Codes](#)

4. DSM 5 classification of substances:

The DSM 5 lists 10 classes of substances that have associated diagnoses:

1. Alcohol
2. Caffeine*
3. Cannabis
4. Hallucinogens (PCP, Other Hallucinogens LSD, DXM, Ketamine)
5. Inhalants (aerosols, gases, nitrites)
6. Opioids (heroin, opioid pain medications such as Dilaudid, OxyContin)
7. Sedatives, hypnotics, or anxiolytics (benzodiazepines, barbiturates)
8. Stimulants (amphetamine-type substances, cocaine, and other stimulants)
9. Tobacco**
10. Other (or unknown) substance

While the specialist should record the class of substance in a client's diagnosis, the specific problematic substance should be identified. For example:

F11.20 Opioid Use Disorder, Moderate (Dilaudid and Heroin).

* For Caffeine Use Disorder: refer client to their Primary Care Physician.

** For Tobacco Use Disorder: refer client to their Primary Care Physician if this is the only substance use disorder - Nicotine Use Disorder is not included on the list of included diagnoses for Drug Medi-Cal. However, if client presents with a Tobacco Use Disorder in conjunction with other substance use disorder(s), staff can treat client with Tobacco Cessation service intervention.

5. **Differential Diagnosis:** When considering a substance use diagnosis, it is important to rule out other factors that may affect a client's presentation of symptoms such as medical conditions and mental health conditions. Therefore, seek guidance/consultation from Program Supervisor and/or Medical Staff.
6. **Meet the ASAM Criteria:** Adults and youth must meet medical necessity for treatment services based upon ASAM criteria.
7. **Medical Necessity is determined every six months through the reauthorization process for ongoing receipt of services (Extended Justification).**
8. **Youth at Risk:** Youth under 21 years old who are assessed as being at risk for developing a substance use disorder will meet two or more of the following criteria at screening:
 1. Difficulties at school related to possession/use/sales of drugs or alcohol including poor school attendance/poor participation/poor grades.
 2. Minor or newly-emerging legal/school issues (e.g. a misdemeanor charge, a possession of tobacco ticket, school suspension or behavior contract) but no arrests or probation involvement.
 3. Self-reported experimentation with drugs and alcohol.
 4. Family history of substance use and/or legal involvement.
 5. Lack of positive family involvement in client's life.
 6. Negative peer influences/association with substance using peers
 7. Client reports having few friends or feeling bullied/socially isolated
 8. Recent death/loss of a significant person in client's life
 9. Youth has recently experienced other major life stressors

REFERRAL SERVICES

Clients who do not meet medical necessity for substance use disorder treatment are referred to other community agencies offering services more appropriate to their needs. The following service needs are assessed and either provided for directly by the Program or referred out and are not limited to: educational opportunities, vocational counseling and training, job referral and placements, legal services, medical services, dental services, social/recreational services, individual counseling and group counseling for clients, spouses, and significant others. All referrals are documented in the client's EHR.

Referrals are typically made via phone conversation with an identified contact person in the appropriate

community agency. Agencies to which referrals are made include Community Health Centers, and other community based providers with the necessary release of information (ROI) in place and signed by the client.

✧ Substance Use Disorder Services ✧

ADMISSION CRITERIA

San Luis Obispo Drug and Alcohol Services provides alcohol and other drug (AOD) services to persons with substance use disorders in the county who meet medical necessity criteria which is assessed for during a walk-in screening appointment. These clients are experiencing functional impairment related to AOD use as defined in the DSM 5 such as managing the everyday activities of life: work, school, family and social functions. Treatment programs are designed to respond to a wide variety of AOD problems and the social, behavioral and psychological issues associated with them.

Counseling staff are responsible for providing medically necessary direct services to clients admitted to the Program. These services include individual and group counseling, crisis intervention, and collateral services. In addition, counseling staff are responsible for maintaining the client clinical record (EHR). This includes the documentation of the client's participation in treatment services, the review and documentation of the client's response to treatment, the preparation of treatment and discharge plans and discharge summaries.

In addition, on the basis of information provided in the initial and any subsequent assessments, clients may, as needed, receive or be referred out for services relating to educational services; vocational counseling and training; job referral and placement; legal services; medical and/or dental services; social/recreational services; and additional individual and/or group counseling services for clients, spouses, parents and other significant people.

County of San Luis Obispo Healthy Agency adheres to the Affordable Care Act § 1557 non-discrimination provisions as follows:

Requirements: The rules general prohibit covered entities from discriminating on the basis of race, color, national origin, sex, age or disability in healthcare programs or activities (45 C.F.R. § 92.101 (a)). Specifically, covered entities may not:

- i. Deny an individual any service, financial aid, or other benefit provided under the program;
- ii. Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others under the program;
- iii. Subject to an individual to segregation or separate treatment in any matter related to his receipt of any service, financial aid, or other benefit under the program;
- iv. Restrict an individual in any way in the enjoyment of any advantage or privilege enjoyed by other receiving any service, financial aid, or other benefit under the program;
- v. Treat an individual differently from others in determining whether he satisfies any admission, enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any service, financial aid, or other benefit provided under the program;

- vi. Deny an individual an opportunity to participate in the program through which provision of services or otherwise cannot afford him an opportunity to do so which is different from that afforded others under the program.

ASAM LEVEL OF CARE

The ASAM Patient Placement Criteria is an instrument to help determine the client's needs and risks and to determine the appropriate level of care. The ASAM Patient Placement Criteria is used during the screening and assessment process, and additionally used throughout the treatment episode to evaluate the client's progress/regression and treatment level needs. For both clinical and financial reasons, the preferable level of care is that which is the least restrictive while still meeting treatment objectives and providing safety and security for the patient. The ASAM Criteria is a single, common standard for assessing patient needs, optimizing placement, determining medical necessity, and documenting the appropriateness of reimbursement. ASAM Criteria uses six unique dimensions, which represent different life areas that together impact any and all assessment, service planning, and level of care placement decisions. The ASAM Criteria structures multidimensional assessment around the six dimensions to provide a common language of holistic, biopsychosocial assessment and treatment across addiction treatment, physical health and mental health services.

The ASAM Criteria provides a consensus based model of placement criteria and matches a patient's severity of SUD illness with treatment levels that run a continuum marked by five basic levels of care.

The level of care is designated:

ASAM Level 0.5: Early Intervention: Client's at risk of developing an SUD or those with an existing SUD. Screening, Brief Intervention, and Referral to Treatment (SBIRT).

ASAM Level 1.0: Outpatient Treatment: Up to 9 hours of service per week of medically necessary services for adults, and less than 6 hours a week for youth. Includes recovery or motivational enhancement therapies/strategies.

ASAM Level 2.1: Intensive Outpatient Treatment: Minimum of 9 hours per week and a maximum of 19 service hours per week for adults, and a minimum of 6 hours to a maximum of 19 service hours per week for youth. Multidimensional instability is treated.

ASAM Level 3.1: Includes both Recovery Residence & Intensive Outpatient Treatment

ASAM Level 3.1, 3.3, 3.5: Residential Treatment: 24-hour structure or 24-hour care.

In San Luis Obispo County, there is one Residential Treatment provider for pregnant and post-partum women. Otherwise, we use the federal (SAMHSA) definition for Residential Treatment which includes pairing a Recovery Residence with an Intensive Outpatient Treatment Program by a certified provider in a structured and coordinated manner (assigned to Level 3.1).

RECOVERY RESIDENCES

Recovery Residences are available for clients who require housing assistance in order to support their health, wellness, and recovery. There is no formal treatment provided at these facilities, however, residents are required to actively participation in outpatient treatment and/or recovery support services during their stay.

Recovery Residences are contracted entities with the County of San Luis Obispo and the Women with Children Residential Treatment Facility is also contracted with the County of San Luis Obispo. The level of care 3.1 necessitates a referral to the provider. The Specialist fills out the Inter-Agency Referral Form (called BH Referral Form found in the assessment menu), approves for payment, signs, and sends to the Program Supervisor to authorization of the referral. The Inter-Agency Referral Form includes a brief description of the client (with the appropriate Release of Information) in order to transition the client. The referrals and placement in Level 3.1 are tracked in the EHR as the County is authorizing this service. The client may also concurrently attend the San Luis Obispo County Drug and Alcohol Services outpatient or intensive outpatient treatment program.

DRUG TESTING DOCUMENTATION

San Luis Obispo Drug and Alcohol Services maintains a highly sophisticated drug testing division of services, including observed (same-gender) random urine screening, laboratory testing for a variety of drug substances, breathalyzer, hair drug testing, oral (saliva) drug testing, sweat patching, on-site random and non-random urine screening. At intake, each client is assigned a 'color' based upon the program they are participating in and based upon each client's individual drug use history which determines the amount of times an individual will drug test during the month as well as the drugs that will be tested for. Based upon subsequent progress in treatment, drug testing 'colors' can be moved up or down in drug testing intensity. Additionally, San Luis Obispo County Drug and Alcohol Services has the ability to order (either randomly or consistently) different more specialized testing such as EtG for alcohol, various other chemicals including spice, opiates, and bath salts.

Urine test results are recorded in the client's EHR in a database called "Client Track." A notification is immediately sent to the primary Specialist for any positive drug testing results in order to have prompt intervention. Positive results are discussed with the client and may be cause for a review of the treatment plan, or increase in level of care or increase in the intensity of the services. Upon continued lack of progress in treatment (not solely based upon drug testing results), a client may be considered for a higher level of care or termination from treatment services.

The Specialist utilizes the client's drug testing history as one measure of progress in treatment. This drug test history can be important in a number of client chart documents such as: progress notes, treatment plans, treatment court reports, and discharge plan/summary.

PREGNANCY

DAS operates a perinatal certified substance use disorder program. For pregnant and postpartum women, medical documentation is necessary to substantiate the pregnancy (verification from the client's physician or verification from a urine screening test at DAS). The last day of pregnancy also must also be substantiated with a medical document (from physician or hospital) that indicates delivery of a child or other outcome.

Documentation of pregnancy status is important because DAS is required to offer additional services to our pregnant clients and those within two months after delivery to address issues specific to pregnant and postpartum women. For pregnant and postpartum women, these services are reimbursed by the state at a higher rate.

Perinatal Services include:

- * Parenting skills and training in child development
- * Access to service (transportation and child care)
- * Education to reduce harmful effects of alcohol and drugs on the mother and fetus
- * Coordination of ancillary services

WITHDRAWAL MANAGEMENT & MEDICATION ASSISTED TREATMENT SERVICES

San Luis Obispo County conducts outpatient Withdrawal Management services and Medication Assisted Treatment (MAT) services through the Nurse Practitioner/Medical Director. All referrals are documented in the client's electronic health record. All detoxification and medication assisted treatment services are documented in the client's electronic health record as conducted by the program's Nurse Practitioner, Licensed Psychiatric Technician, DAS Specialist, and DAS Case Manager.

Medication Services for Drug & Alcohol Services includes: the prescription or administration of medication related to substance use disorders, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure.

✧ SUD Screening ✧

SCREENING (WALK-INS)

Walk-in clinics are available at the four Drug and Alcohol Services clinics on a weekly basis. In addition, the public may call to schedule a screening appointment at a more convenient time as needed. The walk-in screening interview is conducted in person at the clinic by an LPHA in order to provide appropriate triage and recommendations. Screening consists of one individual face-to-face session. If it is determined that a client meets the admission criteria outlined above, this will be noted in the case file and he/she will be scheduled for an assessment appointment. Those that do not meet the criteria for admission will be referred to a more appropriate provider in the community. Clients who present with serious emotional disturbance or severe and persistent mental illness are referred to County Mental Health Services for appropriate treatment or if the Client presents with a Co-occurring Disorder, the referral is to the Co-Occurring Disorders Program of the Behavioral Health Department. Clients with severe SUD impairment requiring a higher level of care will be referred to the appropriate modality within the County's SUD treatment system or to out of County providers as needed. Client disposition will be: 1) admitted to a County Program; 2) does not currently need any treatment services; or else 3) a referral out will be noted in the BH Initial Screening form in the EHR. The Initial Screening indicates meeting the medical necessity criteria for a Substance Use Disorder as defined in the DSM 5.

Prior to the screening session, the client completes the consent for treatment form and any relevant Authorizations to Exchange Information are signed. The client is advised of his/her rights and provided with a copy of the Client Handbook. The screening session is the first billable service, and at this point the client is formally admitted to treatment and assigned to a drug testing protocol. An assessment appointment is made with the client's admitting LPHA/Specialist. If additional immediate outpatient treatment services are needed, the client can be assigned to begin groups and educational sessions immediately prior to assessment with a primary Specialist.

BH INITIAL SCREENING

The assessment document utilized for the walk-in screening is called the **Behavioral Health Initial Screening**. Screenings are conducted by LPHA's or Program Supervisors. The BH Initial Screening assists the Specialist/Assessment Coordinator with gathering information about the client's basic needs, current substance use and substance use history, mental health status, and any past or immediate risk factors such as suicidality, homelessness and emergency physical health needs. It is in this document that the Specialist/Assessment Coordinator establishes medical necessity for treatment services and makes preliminary recommendations for treatment including level of care and drug testing. This form is also utilized by Mental Health for screenings.

SCREENING FREQUENTLY ASKED QUESTIONS

How do I find the BH Initial Screening in Anasazi?

The BH Initial Screening Tool is launched by opening an assessment labeled "BH Initial Screening" or BHIS.

What information is critical to obtain during the screening?

It is imperative that every question on the BH Initial Screening Tool is answered, that medical necessity for treatment services is established, and that risk to self and others is assessed.

What signatures are required on the BH Initial Screening?

Because screenings/assessments are completed by licensed or licensed-track clinicians, the LPHA signature is the sole signature required on this document.

[Screening Progress Note Example \(Click here to jump to example\)](#)

DIAGNOSTIC REVIEW

In the gathering of the client's history, a diagnosis is tentatively developed by the Specialist/Assessment Coordinator and recorded on the Diagnostic Review form in the EHR on the date of walk-in screening.

The Diagnostic Review contains important clinical information used to determine medical necessity for Substance Use Disorder Treatment. It also contains information needed for billing. Diagnosis changes are made by adding a *new* Diagnostic Review. Every client must have a current, Diagnostic Review with Drug Medi-Cal included DSM 5 diagnostic codes.

DIAGNOSTIC RECONCILIATION

Anasazi brings forward all previously entered diagnoses to the current Diagnostic Review. As a result, a client could acquire multiple, sometimes conflicting diagnoses if staff add new diagnoses without ending those that are no longer applicable.

Every active diagnosis must be reviewed for consistency each time a Diagnostic Review is completed. If diagnostic criteria continue to be met, the diagnosis remains active (no End Date is entered). Enter an End Date for every diagnosis that is no longer applicable.

Carefully evaluate multiple diagnoses within a class to determine if contradictory diagnoses exist. Often, rendering a specific diagnosis should result in ending a more general diagnosis of the same class. Some diagnoses have exclusions and cannot occur at the same time as another diagnosis.

Case Example: Alcohol Use Disorder, Mild, was initially diagnosed during walk-in screening. However, after gathering information from Probation Officer and Spouse (with ROI's in place), and following the client's assessment appointment, it is clear that the diagnosis is Alcohol Use Disorder, Severe. The diagnosis of Alcohol Use Disorder, Mild, must be ended because Severe is a more accurate for the client's presenting problem. The begin date for the Alcohol Use Disorder, Severe, is the day it was rendered, and the end date for Alcohol Use Disorder, Mild, is the day before.

SECTIONS OF THE DIAGNOSTIC FORM

1. Summary Narrative: LPHA may provide narrative to establish medical criteria of a SUD, or LPHA refers reader to an assessment that contains that information (BH Screening Tool and/or SUD Assessment). If supporting symptoms are listed on an assessment, assessment update, or other clinical document, they do not have to be repeated on the Diagnostic Review. Write "See Assessment dated xx/xx/xx for detail" in this summarize symptoms text box. Any other time a Diagnostic Review is completed, the primary SUD diagnosis must be justified in the summary text box.

2. Active Diagnoses: LPHA or a medical provider must include a diagnosis from the SUD DSM 5 Codes to establish medical necessity for treatment services. The order of diagnosis is not important.

3. Rule Outs: May include a rule out Diagnosis or be left blank.

4. Summary of Medical Issues: Allows staff of any discipline to document the **client's report** of medical problems in the client's words (does not imply that the staff member quoting is making a medical diagnosis). Example: "Client reports high blood pressure, asthma, and diabetes."

5. General Medical Condition Summary Codes: This is a required field and allows staff of any discipline to document the **client's report** of medical problems in a general manner (does not imply that the staff member is making a medical diagnosis). If no medical condition is known, use "00" for No General Medical Condition or "99" for Unknown/Not Reported.

6. Psychosocial and Contextual Factors Narrative: The Specialist may include a psychosocial factor narrative or this may be left blank. The Specialist may refer the reader to an assessment that contains the psychosocial information (BH Screening Tool and/or SUD Assessment). Psychosocial factors are helpful in understanding the client's history and challenges.

7. Psychosocial Diagnoses: Specialist may provide a diagnosis for psychosocial contextual factors or this may be left blank.

8. What does “SMI/SED Status” mean?:

Mental Health staff enters in SMI/SED Status. Drug and Alcohol staff can choose “Not Coded.” In the event that you share a common client with Mental Health, please do not change this code. Here are definitions of SMI and SED:

- a) “SMI” = Serious Mental Illness. This is a state reporting element that applies to any adult (18 and over) who has an included diagnosis and a significant functional impairment. SMI is similar to, but less strict than Medical Necessity criteria. Adults who meet Medical Necessity criteria also meet SMI criteria.
- b) “SED” = Serious Emotional Disturbance. This is a state reporting element that applies to any youth under age 18 who has an included diagnosis and a significant functional impairment. SED is similar to, but less strict than Medical Necessity criteria. Some youth qualify for services due to “a reasonable probability that they will not progress developmentally as individually appropriate” without current functional impairments, but most youth clients who meet Medical Necessity criteria also meet SED criteria.

9. How is “Experienced Trauma” defined?: “Experienced Trauma?” is a state reporting element for Mental Health and thus please do not change this code if the client is active with Mental Health. This is a required question, and therefore a LPHA must enter Yes, No, or Unknown. A “Yes” answer does not automatically imply that the client experiences any difficulties related to the trauma (e.g., PTSD). Trauma includes:

- Witnessing or being a victim of crime or violence
- Living through a natural disaster
- Witnessing or being a combatant or civilian in a war zone
- Witnessing or being a victim of a severe accident
- Witnessing or being a victim of physical, emotional or sexual abuse

10. Diagnostic Impressions/Conclusions: LPHA provides a conclusion or refers the reader to an assessment that contains conclusion information (BH Screening Tool and/or SUD Assessment).

CLIENTS SHARED BY DAS and MH

Only one current, active Diagnostic Review can exist in a client record at a time, which creates a challenge when clients receive services from both DAS and MH. The Diagnostic Review must accurately reflect the client’s clinical presentation, meet the documentation standards of both DAS and MH, and support billing/reporting functions for all servers involved in a client’s treatment. Collaboration to determine an agreed upon diagnosis for clients shared by DAS and MH is vital.

Anasazi automatically identifies the highest priority Substance Use Disorder for DAS billing claims and the highest priority mental health diagnosis for Mental Health claims. For billing purposes, it does not matter which diagnosis is listed first in the Diagnostic Review for shared clients.

Completing Diagnostic Reviews for Shared Clients:

Client opened and diagnosed by MH, later diagnosed by DAS

DAS staff:

- May add, edit, or end Substance Use Disorders

- May add MH diagnoses (Licensed or Licensed Track DAS staff only) but cannot change the MH diagnoses set by MH staff (MH may have billing tied to this diagnosis) without first consulting with MH staff.

Client opened and diagnosed by DAS, later diagnosed by MH

MH staff:

- May add, edit, or end MH diagnoses
- May add Substance Use Disorders but cannot change Substance Use Disorders set by DAS staff (DAS may have billing tied to this diagnosis) without first consulting with DAS staff.

CHANGING A DIAGNOSIS

The client's working diagnosis in Anasazi is documented on the Diagnostic Review. Formulations written in Progress Notes or other assessments do not change the Diagnostic Review. If a diagnosis change is made following an evaluation by an MD/DO/NP, for example, the Diagnostic Review must be updated to reflect the new diagnosis. The new diagnosis may be entered by any agreed upon member of the treatment team, but should be routed to the staff member who rendered the diagnosis for approval if the staff member who enters the diagnosis is not an Approved Category of Staff.

When changing a diagnosis, remember "End yesterday, begin today" or "No gaps, no overlaps."

CO-OCCURRING DISORDER DIAGNOSTIC

Co-Occurring Disorder Treatment is an evidenced based program wherein the substance use disorder is treated concurrently with the client's mental health issues. DAS has specific clinicians that treat Co-Occurring Disorders. These LPHA staff members are able to diagnose both substance use disorders and mental health disorders.

DIAGNOSTIC REVIEW FREQUENTLY ASKED QUESTIONS:

Where do I find the diagnostic review in Anasazi?

The Diagnostic Review is an assessment form which can be found in the assessment menu (DIAG – Diagnostic Review Form).

What date do I use for the diagnostic review?

The diagnostic review should be dated on or before the date of the first billable service. For DAS the first billable service is screening at walk-in. Billing cannot begin without an approved diagnostic.

How often must a Diagnostic Review be completed?

1. When first receiving services (walk-in screening, crisis contact, PHF admission).
2. Whenever a change of diagnosis is indicated, including at discharge.

Who completes and signs a Diagnostic Review?

Diagnostic Reviews are completed by staff within established scopes of practice. LPHA Staff are responsible for making and updating the diagnosis. Interns without waiver and all trainees require clinical co-signature from a Program Supervisor.

1. LPTs and LVNs cannot render a diagnosis, but can assist by documenting symptoms (Business and Professions Code, Division 2 Chapter 10 Section 4502 b) in the text boxes above each axis.
2. An approved paper or electronic document completed and signed by an LPHA as part of the medical record can be used as a reference for entering diagnostic information. For example, a Mental Health Evaluation Team interview is often (for now) a paper document, but contains a diagnosis and signature by an LPHA Staff. The person entering the diagnosis must reference the source document in the text box at the top of the Diagnostic Review (e.g., "See MHET Crisis Interview, completed by Chris S. Worker, LMFT, dated 1/1/2016 for detail") and sign as "Staff Entering the Diagnosis". Any staff member, including Front Office staff, can enter a diagnosis rendered by an LPHA in this manner. If LPHA who rendered the diagnosis uses Anasazi, route the Diagnostic Review to him or her for signature. This interim process is in effect until all providers directly enter information in Anasazi.
3. MD/DO/NP signature is not needed if an LPHA signed a Diagnostic Review.
4. The treating MD/DO/NP must concur with the ongoing diagnosis when medication support services are provided. In some instances, the Diagnostic Review will reflect the working diagnosis of the MD/DO/NP.

Where else must the client's diagnosis be documented in the clinical record?

Medical necessity is established during screening (BH Screening Tool) and assessment (SUD Assessment), and is also included on the client's treatment plan to meet Title 22 requirements. DMC-ODS requires that the diagnosis also be included on the client's treatment plan.

A previous DAS/MH client came back into services and has a diagnostic with DSM IV codes. How do I update this to reflect DSM 5 codes?

The how to guide for ICD10 conversion can be found here: S:\DAS Documentation Support\Tip & Cheat Sheets\DSM 5 and ICD 10 in Anasazi.

What if there is a difference of opinion about a client's diagnosis?

Although it can be worthwhile for the members of the treatment team to have a difference of opinion, eventually it is in the best interest of the client that the team discusses and agrees on a unified diagnosis. If an agreement is reached, a clinician updates the diagnosis. If an agreement is not reached, a Clinical Supervisor is consulted.

✧ Admission Procedure ✧

ASSESSMENT

Definition

Assessment is the process of gathering and analyzing history, observing behavior, and obtaining information from a client and occasionally from significant others to formulate a comprehensive view of a client's strengths and needs. The process leads to a diagnostic formulation, a medical necessity determination, and an initial treatment recommendation. The process may be completed in one session, or if necessary, may be completed in up to 2 sessions beyond the initial walk-in screening.

If the client is appropriate for treatment and the client is admitted, at the assessment appointment, the following information will be gathered: social, economic, and family background, education, vocational achievements,

criminal history and legal status, drug history, and previous treatment. The Assessment process includes: **SUD Assessment**, and the **CalOMS** data gathering form in the EHR. Use of the ASAM Criteria ensures a correct assessment for the client's Level of Care. See the detailed admission procedures listed below.

Limits of confidentiality and risks/benefits of treatment must be explained at the beginning of the assessment process and revisited as often as needed to ensure that the client understands program requirements and their personal rights.

ADMISSION OVERVIEW

1. Screening (Walk-In), Visit 1

- a) Introduction to program, describe the treatment process
- b) Discussion of presenting problem (Substance Use Disorder & Interference with functioning)
- c) Obtain medical history (Health Questionnaire)
- d) Review Health Questionnaire with Client, give referrals if necessary
- c) Conduct a Diagnostic Review in accordance with DSM 5 criteria
- e) Obtain consent for treatment
- f) Establish medical necessity and schedule assessment appointment

2. Assessment, Visit 1

- a) Administer SUD Assessment
- b) Conduct the ASAM Patient Placement Criteria

3. Assessment, Visit 2 (if needed, or complete during visit 1)

- a) Discuss SUD Assessment findings including level of care recommendation
- b) Obtain CalOMS Admission data
- d) Administer any other applicable assessment tools

4. Treatment Planning, Visit 1 with Primary Counselor (Specialist)

- a) Discuss assessment findings as the starting point for life change
- b) Identify strengths as well as weaknesses, supports and barriers to recovery
- c) Develop specific short and long term goals including action steps with client
- d) Client to sign the Treatment Plan, if completed

5. Treatment Planning, Visit 2 with Primary Counselor (Specialist)

- a) As needed to continue the work begun in the first visit, Client to sign the Treatment Plan
- b) As necessary, treatment planning sessions may be provided when a change in treatment plan is warranted, either at 90 days or earlier if there are clinically significant changes in the client's life or progress is not being made in the existing treatment plan.

SUD ASSESSMENT (SAASAML)

The Specialist/Assessment-Coordinator conducts the initial intake assessment utilizing the SUD Assessment (SAASML). The assessment includes a review of the client's history and current status and risk factors in the 6 dimensions of the ASAM (Withdraw/Intoxication, Medical, Emotional/Behavioral, Relapse Potential, Recovery

Environment, and Stage of Change) and life domains including legal status and employment/education. In addition, a family assessment session can be conducted with members of the client's family to better ascertain the extent to which they are ready, willing and able to participate in the treatment process.

Recognizing that a client may not be willing to disclose sensitive personal information prior to the development of rapport with the Specialist and engagement in treatment, the assessment is an ongoing process. Initial assessment information is updated as the client is willing to share more information about themselves over the course of treatment.

Some assessment activities must be conducted face-to-face with the client. A Mental Status examination and behavioral observation to formulate initial diagnostic impressions are examples.

Other assessment activities may be performed either face-to-face or by telephone, and may involve family members or other significant parties without the client. For example, sensitive family and developmental history may be better collected in a separate session with the parent of a youth rather than with the youth present. If the purpose of the contact is to gather information for an intake assessment, the service is coded as "Collateral" (Service Code 2003).

Note: The assessment process must include a face-to-face meeting with the client to be complete. If an assessment is started but is not completed because the client terminates the contact or does not keep a follow up appointment, complete the assessment to the degree possible and document the reason for the incomplete assessment in the Recommendations/Plan of Action section and on a Progress Note. Add a Staff signature line with the heading "Incomplete Record Confirmation" to the assessment to affirm that the assessment is not complete and close the case.

The level of care is documented on the SUD Assessment, along with other treatment recommendations and a safety plan. The areas included on the SUD Assessment form are:

- 6 ASAM Dimensions
- Risk factors for each dimension
- Additional Legal and Employment/Education Life Areas
- Level of Care Recommended
- Level of Care Received
- Explanation if there is a different level of care received than recommended.

In summary, the assessment process includes 1-2 individual sessions conducted in the first 30 days of admission:

1. SUD Assessment
2. CalOMS Admission Questionnaire
3. Review of the Health Questionnaire: recommendations and referrals given

Other optional assessment tools may be used during the assessment process including: Beck Depression Inventory, Substance Abuse Subtle Screening Inventory (SASSI-3), GAIN-SS, GPRA questionnaire, Mental Health Adult/Youth Assessment, etc.

ASSESSMENT FREQUENTLY ASKED QUESTIONS:

Where do I find the SUD Assessment in Anasazi?

The SUD Assessment is an assessment form which can be found in the assessment menu (SAASAML). Create the assessment with the date that the assessment interview took place.

What information is critical to obtain during the assessment?

It is imperative that every question on the assessment is answered. Assessments must have risk questions answered and include the medical necessity information.

What is the safety plan section on the SUD Assessment for?

The safety planning section is used to plan for the client's sober activities until they are scheduled to start treatment. This section can also be used to document a Specialist's risk assessment and subsequent safety planning for client that present with risk issue (suicidal ideation, self-injurious behaviors, and domestic violence for example).

What signatures are required on the SUD Assessment?

The SUD Assessment is signed by an LPHA and Program Supervisor.

[Assessment Progress Note Example \(Click here to jump to example\).](#)

ASSESSMENT PROGRESS NOTE Tips:

- Clinicians must give and review informational material with every client, in a language understood by the client, at the intake appointment.
- The number of assessment sessions and total time for the assessment must be reasonable and supported by the documentation contained in the Progress Notes and in the intake assessment form. Most comprehensive assessments will be completed in about 1-2 hours on average. Some cases require less time, while other, exceptionally complex cases may require more time.
- If a therapist sees a client on Monday and finishes the paperwork on Tuesday (when client is not present), the time spent on paperwork is added to Monday's assessment and billed as one bundled service. The write up is an important part of the assessment process, but it is not a separate, stand-alone service.
- Bundle interview, record review, time spent formulating and completing the Assessment in Anasazi as "Service" duration on the Progress Note Billing Ribbon.

CalOMS

CalOMS Treatment (CalOMS Tx) is California's data collection and reporting system for substance use disorder (SUD) treatment services. The State collects data and compares admission, annual updates, and discharges to measure individual client progress, and uses the same bench marks to compare between types of service and counties. Treatment providers send client treatment data to DHCS each month. This treatment data builds a comprehensive picture of: client behavior, alcohol/drug use, employment and education, legal/criminal justice, medical/physical health, mental health, and social/family life. Summary reports, created from this treatment

outcome data, contribute to the understanding of treatment and the improvement of substance use disorder treatment programs in the continuum of prevention, treatment and recovery services. By telling the story of substance use disorders and recovery in California, CalOMS Tx provides rich data for improving treatment outcomes, supporting effective funding, and for legally mandated federal and state reporting requirements.

The CalOMS is completed at treatment admission for Adult and Youth admissions. The CalOMS must be dated the same date as when the client assignment was open (this is called a subunit). A client assignment is when the client is assigned to a program and to a Specialist (Single Accountable Individual – SAI). The CalOMS type at admission must match the CalOMS type at discharge (type 1, 2, 3).

A CalOMS is only opened for treatment admissions. CalOMS is not opened when a subunit is opened for Case Management nor for Recovery Residence.

CalOMS FREQUENTLY ASKED QUESTIONS:

Where do I find CalOMS in Anasazi?

To access a new CalOMS, go to the Assessment tab of your Clinician Home Page and choose New Assessment. When the assessment type prompt opens, chose the type of CalOMS form you are completing:

CALAADM CalOMS Adult Admission

CALADSCH CalOMS Adult Discharge

CALAUPD CalOMS Adult Update

CALYADM CalOMS Youth Admission

CALYDSCH CalOMS Youth Discharge

CALYUPD CalOMS Youth Update

What do I date the CalOMS?

In most cases, the opening admission CalOMS will be the date of walk-in screening. A CalOMS does not need to be opened for a case management subunit.

What signatures are needed on the CalOMS?

The Specialist obtaining the information signs the form and then assigns the form to the designated Health Information Technician (HIT) for approval.

[Click here to jump to Appendix F for CalOMS cheat sheet](#)

CALIFORNIA MULTIPLE ENTRY WINDOW (California MEW)

The California MEW contains the Alcohol/Drug Use History for the client. The first 6 fields of the MEW are for the Primary and Secondary drugs of choice (Priority 1 & 2) and are included in the client's CalOMS file that is sent to the State. The California MEW is embedded in several of the assessments in Anasazi: BH Initial Screening Tool, SUD Assessment, and CalOMS.

It is important that the California MEW be accurate and updated because:

1. The information in the California MEW flows into the client's CalOMS at time of Admit, Annual Update, and Discharge. When a CalOMS form is launched, Anasazi pulls forward the MEW information from the last final approved assessment that contained the California MEW.

Example: The California MEW is entered in the BH Screening Tool at the time of walk-in screening. As long as the BH Screening Tool is final approved prior to launching the admission CalOMS, then the MEW information will pre-populate into the CalOMS.

However, if the BH Screening Tool is not final approved prior to launching an admission CalOMS, the MEW on the CalOMS will be blank and will need to be manually entered. This is true of any of the assessments that include a California MEW - if there is another final approved assessment with a MEW in Anasazi, the last final approved assessment with the MEW will prepopulate into the new assessment that is being launched. **This means that errors, if not watched carefully, will move forward into multiple assessments and old out of date information can get pushed forward into new assessments.**

2. The California MEW prepopulates into an area of a number of assessments, and thus it is necessary that Specialists open each area of the MEW (by double clicking on the substance name) to ensure that the information is correct and not something that is out of date. This is particularly critical at time of discharge to ensure that the CalOMS discharge drug choice and usage is in agreement with the assignment close reason. At discharge, the California MEW is first updated in the OPDC Summary/Plan, and this assures that the same information will pull forward to the CalOMS and close reason. For example, a successful completion of treatment should have no use in the past 30 days.
3. CalOMS forms have rules about how information in the MEW can be filled out. Therefore, if the rules are not followed on one assessment that contains a California MEW, the issue will be carried forward and if not caught, will cause the CalOMS to become suspended. The most common problems in the MEW that cause a CalOMS to suspend are:

- a. **The Drug Name field is filled in for a specific drug.**

Example: Alcohol is the primary drug, however the Specialist enters "Beer" into the drug name.
Example: Marijuana is primary drug, however the Specialist enters "2 blunts" in the Drug Name field. In both cases, the drug is a specific labeled drug, therefore the Drug Name field should be left blank

- b. **The Drug Name field is left blank and the Alcohol/Drug Problem is a generic drug.** In these cases, the CalOMS will suspend if the Specialist does not name the drug. The Specialist must name the actual substance being used in a larger class. Example: Drug Name is Other Opiates/Synthetics, and the Specialist names Dilaudid as the drug being abused.

- c. **The Age of First Use is left blank, or is a number less than 5, or the Unable to Answer box is chosen.**

CalOMS Rules: 5 is the youngest age you can use. Never use "unable to answer."

✧ Treatment Plans: Development and Approval Process ✧

A valid and current Treatment Plan, completed with client participation and agreement, is a legal and contractual requirement for ongoing services. Treatment plans are based upon client needs as determined by the screening (BH Screening Tool, Diagnostic Review) and the admission procedure (SUD Assessment, CalOMS), and are developed together with the client and his/her family if appropriate. On the basis of a thorough individual assessment, a treatment plan is developed to address the individualized needs of the client. The scope, frequency and duration of treatment services are directly correlated to the severity of impairment in functioning. At the outset, the amount and type of treatment a client receives is established on the basis of the assessment and treatment plan.

The Specialist shall prepare an individualized written treatment plan, based upon information obtained in the screening and assessment process. The treatment plan will be completed within the first 30 days of admission, and then updated every subsequent 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan. Examples are: level of care change, change in medical status (ex. Pregnancy), etc. The treatment plan shall include: a statement of problems to be addressed, goals to be reached which address each problem, action steps which will be taken by the provider and/or client to accomplish identified goals, target dates for accomplishment of action steps and goals, and a description of services including the type of counseling to be provided and the frequency and duration thereof. Issues identified during the screening and assessment process must be listed as a problem statement on the treatment plan. Treatment plans have specific quantifiable goal/treatment objectives related the client's substance use disorder diagnosis and multidimensional assessment. The treatment plan will identify the proposed type(s) of interventions/modality that includes a proposed frequency and duration. The treatment plan will be consistent with the qualifying diagnosis and will be signed by the client, Specialist, LPHA/Program Supervisor, and the Medical Director.

The client's primary Specialist will meet with the client and work together to develop an individualized treatment plan, including strengths and weaknesses, problem statement, goals, objectives, and interventions. The Treatment Planning can occur over 1-2 individual sessions. The Medical Director will review, sign, and admit each client to the Program. This is evidenced by the Medical Director's signature on the client's Treatment Plan within 15 days of the Specialist's signature.

TREATMENT PLAN TIMELINES

SA INITIAL TREATMENT PLAN (SA ITP)

The Assessment Coordinator/Specialist opens an ITP at walk-in screening, beginning a 30 day period during which a formal Treatment Plan must be developed for ongoing care.

SA TREATMENT PLANS (SA TP)

A treatment plan is developed based on the information obtained during the walk-in screening and assessment and treatment planning sessions. Therefore the treatment plan is individualized with goals, objective, and interventions that fit the needs of the client identified during assessment. The treatment plan is completed by the Specialist and reviewed by the Program Supervisor within 30 days of admission to the program. At a minimum, the treatment plan is reviewed and updated every 90 days thereafter or when a change in problem identification

or focus of treatment occurs, whichever comes first. Independent of the 90 day requirement, the treatment plan may be updated whenever clinically significant changes occur in the client's life or as the client may disclose new information to the Specialist.

A NOTE ABOUT INTERIM SERVICE LOGS (ISL's)

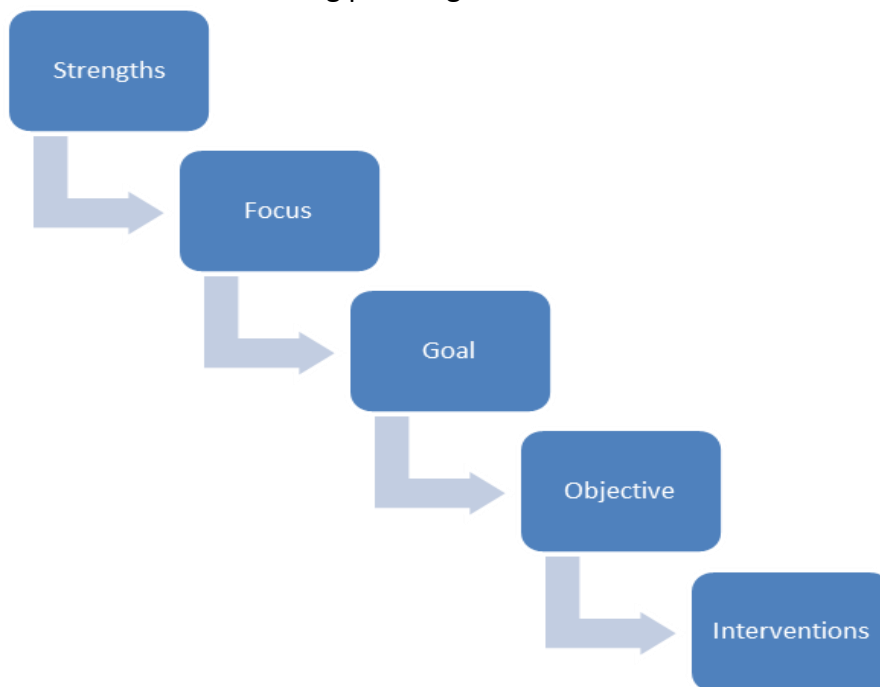
An ISL allows Progress Notes to be written to document a missed intake assessment or contacts which occur prior to an intake. Most cases will begin with an ITP, not an ISL. Please see the appendix for circumstances in which use of an ISL is approved.

Note: It is NOT acceptable to add an ISL after an ITP or TP have expired without specific Program Supervisor and QST Division Manager approval. **In almost every case, the appropriate action is to create a valid TP.**

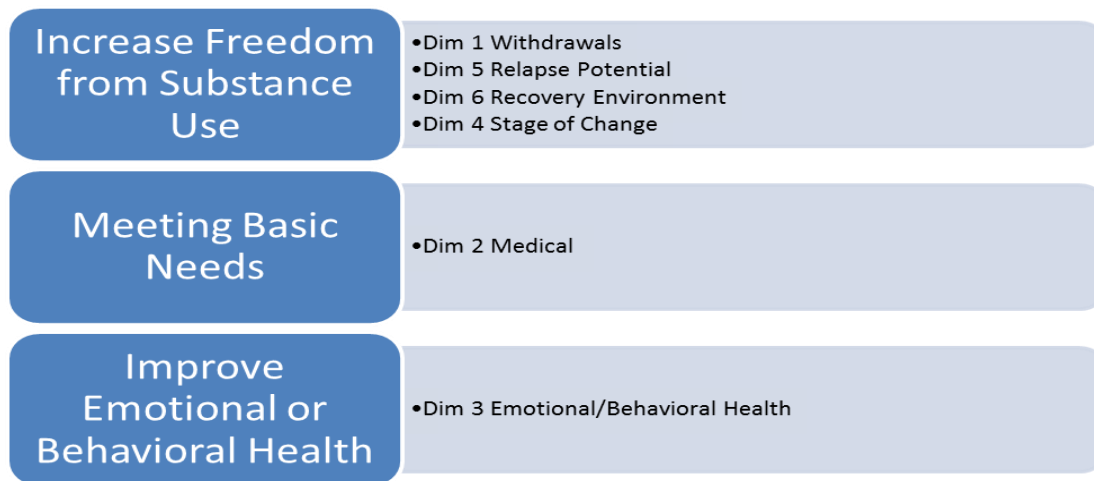
[Click here to see Appendix I for ISL Policy](#)

GUIDELINES FOR COMPLETING PLANNING TIERS

The treatment plan is created with the following planning tiers:



Goals and Objectives match the focus of treatment and problems identified in the screening (BH Initial Screening document) and assessment (SUD Assessment document) sessions. A Specialist might conceptualize a treatment plan from an ASAM perspective like this:



Strengths:

- Strengths are qualities useful in helping the client attain TP goals.
- Engage client in a discussion about their strengths and chose their responses. Tier Narrative is required.
- 3 strengths are required.

Focus of Treatment:



- Must include a personalized focus of treatment as a problem statement that is to be addressed.
- Planning Tier narrative is required.
- Must include the assignment of a Specialist in the narrative.
- Symptoms should be a cluster (e.g., depression) rather than an exhaustive DSM list.
- Functional impairment must be clearly stated and explicitly linked to symptom cluster (e.g., Jack reports that his substance use disorder has caused barriers in the ability to live a successful life as evidenced by health issues, care for self/others/children..."").
- Target date is included.

Goals:

↑ **Positive Coping** or ↓ **Functional Impairment**

- Must include goals to be reached which address each problem/risk factors covered in the ASAM Placement Criteria.
- Must include target dates for the accomplishment of goals.
- Goals restate the *functional impairment* in a broad manner and guide treatment in reducing the impairment.

- Planning Tier Narrative is required.
- Select Goal(s) that match the functional impairment documented in the Focus of Treatment Planning Tier Narrative. This helps establish a clear link between the impairment and the Goal (e.g., if the impairment is interpersonal relationship related, select “Improve Family Relationships” as a goal).
- Select only the Goals that will be an active focus of treatment – keep the plan as simple as possible.

Objectives:

What will the client do?

- ✓ **Personal**
- ✓ **Measurable or Observable**
- ✓ **Linked to Goal**

- Must include action steps which will be taken by the provider, and/or the client to accomplish the identified goals.
- Must include target dates for the accomplishment of action steps.
- Planning Tier Narrative is required.
- Objective is personalized, made observable or measurable, and directly linked to the Goal.
- Select only those Objectives that are an active focus of treatment – keep it simple!
- Select only those Objectives that allow all the Interventions to be clearly and logically linked.

Interventions:

What will staff do?

- An Intervention is what staff will do to help a client accomplish an Objective.
- An Intervention is a service (and a service code).
- Multiple Interventions may be linked to an Objective, but only if each links logically to the Objective.
- Planning Tier Narrative is required for all Interventions, and must include a detailed description of the intervention to be provided.
- Frequency and duration of the service must be in the drop down fields.
- Ad Hoc can be chosen for Individual Counseling if appropriate.
- Drug testing color is included in the drug testing intervention narrative.
- EBP interventions are added under goals/objectives that logically link.

Examples:

Group Counseling: “Group counseling sessions will consist of discussing new skills to cope with the impulses associated with addiction.”

Med Training: “MD and LPT will provide medication education and monitoring.”

Individual Counseling: “Specialist will provide CBT & Solution Focused interventions.”

[Click here to view a sample Planning Tier Narratives](#)

REVISE, REVIEW, AND ADD NEW TREATMENT PLAN

Revise, Review, and Add a New Treatment Plan are three options available to a clinician at the end of a 90 day treatment plan or if the TP must be modified to meet the client's needs. The following can be used as a guide in deciding which option to select.

Review:

- **Only Use Review (Do Not Use Revise)**
- Involves a comprehensive look at the entire set of Interventions and progress made by the client.
- Establishes a new **End Date** for the TP (90 days).
- A TP Review should be completed when:
 - The TP needs to be updated for the next review period.
 - When New Goals, Objectives or Interventions are needed.

Add a New Treatment Plan:

- If you want to start with a “clean slate” rather than Review an old TP, end the old TP and add “New Treatment Plan” from the Staff Panel of Clinician's Homepage.
- No elements from the previous TP will import – you must add and personalize each element, but you won't have to delete old Planning Tiers.

FREQUENTLY ASKED TREATMENT PLANNING QUESTIONS:

What signatures are required on a treatment plan?

Client, Specialist, and Program Supervisor.

The Specialist must sign the TP by the day that the TP starts to avoid disallowed services. The Specialist can sign the TP earlier than the date that the TP starts, up to 14 days before, however it is best to sign close to the start of the TP. Best practice is for Client and Specialist to sign the TP at the same time, however, as long as the Specialist signs by the date that the TP starts there will not be “unplanned” (disallowed) services. The Specialist will assign the Program Supervisor to the TP at the same time that the Specialist signs the TP.

I have a Youth client. What signatures are required on the Treatment Plan?

Please see Appendix H for signature information for DAS Youth Treatment Plans.

[Click here to jump to Appedix H: Youth Clients](#)

TREATMENT PLANS IN SPANISH

Clients who prefer to receive services in Spanish will receive a TP written in Spanish and English. Bilingual staff create a TP in Anasazi using the English-language planning tiers and personalize Tier Narratives in English according to the instructions above. In addition, bilingual staff or Promotores interpreters translate the Planning Tier and any personalized text in each Tier Narrative text box. It is important that the TP is written in English and Spanish in Anasazi, as the Spanish translation is proof that the TP was developed in the client's primary language. Strengths, Focus of Treatment, Goals, Objectives and Interventions have been translated and are available for bilingual staff. Signature requirements are the same for all clients.

Reminder:

Services provided in Spanish, whether by clinical staff or interpreter, are coded with Contact Type “S” (Face-to-face Spanish) or “P” (Telephone Spanish).

TREATMENT PLAN TIPS:

- Remember to keep the TP simple and usable for the client – it is their document.
- Clients in one level of care, should not have interventions on their treatment plan for a different level of care (ex: client in Outpatient Level 1.0 would not have Level 2.1 interventions on their treatment plan).
- Target Dates must be consistent with end date of treatment plan for the Focus of Treatment, Goals, and Interventions.
- Treatment plans must be individualized: Client’s name is used, individual psychosocial factors are addressed such as health, pregnancy, family relationships, legal status, etc.

[Click here to view a sample Treatment Plan](#)

[Click here for a sample Plan Development Individual Service Progress Note](#)

✧ Progress Notes ✧

GENERAL CONSIDERATIONS

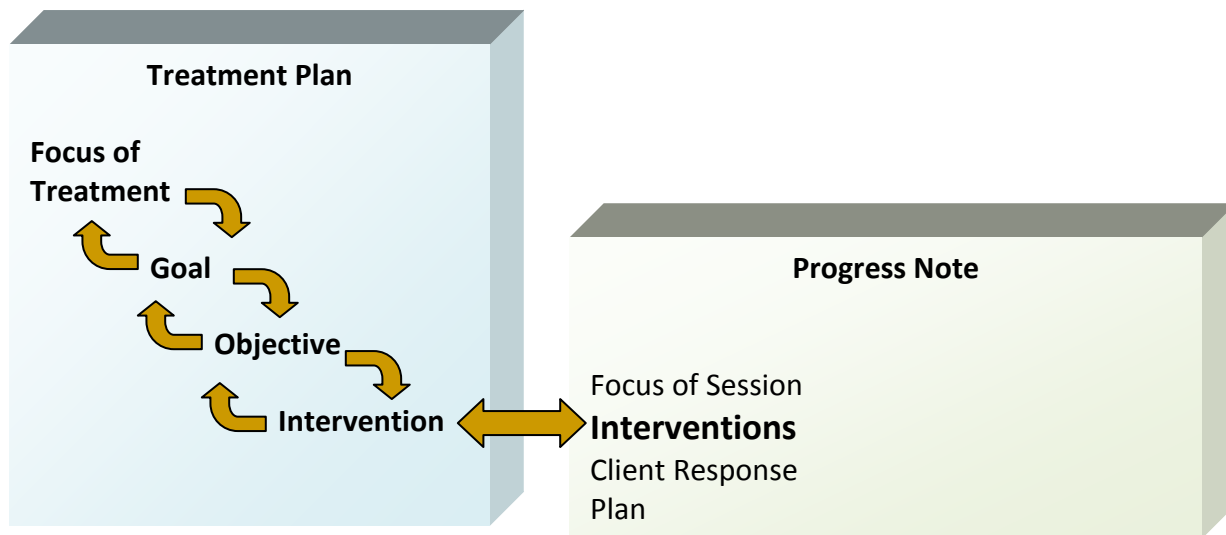
Progress Notes are the heart of the clinical record. A service provided for a client, regardless how powerful or effective, is incomplete until documented. Effective documentation of clinical interventions is a professional, legal and ethical responsibility of all clinical staff.

Progress Notes must document relevant aspects of client care, including clinical decisions made, interventions used, and referrals given to the client. Extraneous information, especially negative comments about other staff members or other clinical disagreements, does not belong in the record!

Progress Notes must describe how the intervention reduced a client’s impairment, restored functioning, or prevented significant deterioration in an important area of life functioning described in the Treatment Plan. In other words, a Progress Note explains what was medically necessary about the service.

Merely reviewing a record, transporting a client or performing clerical tasks are not billable services, because no intervention occurred that would benefit the client.

Progress Notes document the link between the client’s diagnoses/impairments (from an assessment or Focus of Treatment on the TP), Objectives (from the TP), and the Interventions provided during the service.



Each client contact is documented in a signed and dated progress note and placed into the EHR. In addition entries in the EHR may be made subsequent to phone contact with the client or their parents, conferences with school or probation staff, or other interaction or communication with the client or another person which provides information that is clinically relevant to the client’s treatment.

San Luis Obispo Drug and Alcohol Services require that client case records are maintained in a legible manner—typed into the EHR. All entries are electronically signed and dated. All information relating to a client and their services at the program is kept in a single case file with a standard format as a result of the EHR. While maintaining appropriate confidentiality safeguards as noted above, records are kept in such a manner to be easily accessible to DAS staff providing services.

A progress note must reflect progress or lack of progress towards the treatment plan problems, goals, objectives, and action steps; however, Drug Medi-Cal regulations do not require that every problem area be addressed in each progress note.

FREQUENCY

Every outpatient service contact must be documented in a Progress Note and on a signed roster if it is a face-to-face contact.

TIMELINESS

Outstanding: On the date of service.

Above Satisfactory: Within 2 calendar days of the date of service.

Satisfactory: The DAS standard is that progress notes must be completed by the end of the business week in which the service occurred.

Unsatisfactory/unbillable: More than 7 days after the date of service. If late documentation occurs regularly, talk with your Program Supervisor about strategies to you can use to get notes completed in a timely manner.

ACCURACY OF BILLING INFORMATION

The service, travel and documentation time in a Progress Note must accurately reflect the time spent providing the service and must be reasonable for the service provided. Refer to the Health Agency's *Fraud, Waste and Abuse Policy* for additional detail.

Service Indicators: The "Billing Ribbon" or "Encounter" contains important billing information. It must be completed before a Progress Note can be 'Final Approved'.

Appendix K lists and defines Service Indicators.

Person Contacted: Staff must select one of several possible values for Person Contacted.

Place: Choose the location that the service took place; office, client home, inpatient setting (PFH or other hospital), other community location, Residential Treatment location, etc.

Contact Type: Indicate the type of contact such as Face-to-face, Telephone, and services provided in Spanish.

Appointment Type: DAS uses ONLY appointment types 1 (Scheduled), 5 (No Show), or 7 (Excused Absence) only.

Service Intensity: Select service intensity type.

Travel Time: Only two case management service codes allow DAS to bill for travel/transportation time (2081, 2082).

Cancellation and FTS:

Edit the Encounter to change the Duration to 0:00.

Edit Appointment Type to "No Show" or "Excused" as appropriate.

APPROPRIATE LANGUAGE IN DOCUMENTATION

Third Party Information: State information gathered from third parties as a report, not a fact (e.g., "Client's father reports that...").

Abbreviations: Standard abbreviations are acceptable in a note. See Appendix B for the list of abbreviations. If you need to abbreviate a word or acronym that is not on this list, spell it out first.

Recovery Language: Documentation must be written using strength-based language that reflects the culture of the client and respect for the collaborative process. Relate your interventions to a recovery oriented paradigm. Remember that a client has broad (and rapidly increasing) access to his/her medical record!

INDIVIDUAL PROGRESS NOTES (BEHAVIORAL HEALTH PROGRESS NOTE TEMPLATE)

The progress note format for the County of San Luis Obispo is: Focus, Intervention, Content, and Progress/Plan or the acronym FICP.

This is the standard format used for most billable outpatient service contacts. The template contains the following sections (*If a section does not apply to your service, type "N/A" in that section*):

Focus of Session: The purpose of this section is to explain why the service occurred and to document any significant symptoms, behaviors or mental status elements noted during the service. The focus of the session links the client's diagnosis and resulting functional impairments to the interventions provided during the current service. When a Progress Note is linked to an Objective from a Treatment Plan (TP), the Focus of Treatment section can be brief. It is not necessary to write an extensive narrative or accounting of disclosures or interactions during a session.

Interventions: Interventions are what staff did for the client during the contact to reduce the client's impairments due to substance use disorder or prevent deterioration in functioning. Clearly written interventions are the primary proof that the service provided was medically necessary and are the most important part of the note. Bulleted phrases or narrative text are equally acceptable writing styles. The interventions must relate to the client's treatment plan. Most interventions are directed toward the client, but sometimes directed toward someone other than the client (e.g. family).

Intervention Starters: Acknowledged, Assisted, Brainstormed, Clarified, Created, Defined, Developed, Discussed, Encouraged, Engaged, Explained, Explored, Facilitated, Identified, Inquired, Modeled, Normalized, Practiced, Praised, Prompted, Provided Feedback, Reframed, Reinforced, Reminded, Reviewed, Solicited, Suggested, Supported.

Client's Response: The Response section is about what the clients or the recipients of the service report or how they react to what you did (to the interventions).

Client Response Starters: Client appeared to be interested, Client acknowledged, Client processed, Client identified, Client sought information, Client was receptive, Client declined.

Progress to the Plan: This section is used to document client progress in treatment. Progress is best discussed in measurable terms (ex "Client has had 3 months of negative drug tests," "Client appears to be working on stabilization of their living environment as evidenced by moving in with a roommate that does not use drugs or alcohol"). This section is used to discuss progress towards treatment plan goals and objectives.

GROUP PROGRESS NOTES

"Overview Progress Note" section:

1. Focus Section: Name of Group or Topic of Group:

Examples: "EBP Matrix Group: Early Recovery, Scheduling", "EBP Seeking Safety: Safety", "EBP Moral Recognition: Honesty"

2. Group Interventions: write your specific skill building interventions for the entire group here.

Examples:

"Taught the group to develop a budget by listing expenses..."

“Modeled effective communication...”

“Rehearsed...”

“Role played...”

“Practiced...”

“Client Progress Note” section:

1. **Client Response:** Individualize the note by listing any interventions or decisions for each group member. Each client has unique interactions with other group members and reaction to the topic, which should be documented clearly in the Client’s Response section.
2. **Progress to the Plan:** Individualize the note by discussing the client’s overall progress or regression in treatment in measurable terms.

The note must accurately record the amount of time each group member participated in the group. For example, if one client is excused to leave the group early, the attended time must be changed for that client. It is fraudulent to not make this change.

ACCURATE GROUP ROSTERS

The Group Roster must include the following elements:

1. Clearly stated topic of the group, (ex. Internal Triggers) not the service code name of the group (ex. Matrix Group).
2. Correct date of service.
3. Correct time of service, including duration of the group with start time and end time.
4. The client(s) must sign their entire name (no initials), next to their printed name, not over it.
5. Black or blue pen must be used (pencil is not accepted).
6. If client is absent, enter in the correct appointment type (ex. 5 No Show, 7 Excused Absence).
7. Specialist must sign the Group Roster with their full name (no initials). If more than one staff conduct a group, both Specialist’s must sign the roster.
8. Rosters are turned in within 24 hours.

A Group can be billed to Drug Medi-Cal if there are between 2-12 participants only. Groups with 1 participant or 13 or more participants need to be changed to an unbillable service.

INFORMATIONAL NOTES

An Informational Note is created when a clinician wants to document an *unscheduled* activity during which no service was provided. Here are some examples:

- Leaving a message or listening to voice mails
- Clerical tasks (e.g. reminder calls to clients, faxing)
- Treatment Court Reports
- Open/Close Cases (open to walk-in, wait-list, or drug testing sub-unit) used to describe why Specialist chose to close the client.

✧ Types of Services ✧

WALK-IN OR ENROLLMENT PROCESS SERVICES:

SA Registration (Service Code 2019): Paperwork process of signing the Application Packet, recorded by clerical staff for court ordered program (DEJ, P36, ADC). Registering/enrolling in a program. Not DMC billable, rather a support function.

SA Screening (Service Code 2020): Face-to-face screening session with client during walk-in. Specialist uses the Service Request, Initial Screening Tool and Diagnostic Review. Screening for medical necessity for a SUD treatment. If client meets medical necessity, this service is billable.

INDIVIDUAL SESSION SERVICES:

A private interaction between a client and a Specialist which focuses on the identification and resolution of alcohol and/or drug-related problems. Also examines personal attitudes and behavior and other barriers to recovery.

Assessment (Service Code 2000): Face-to-face assessment session with client. Specialist uses the CalOMS, SUD Assessment, ASAM, GPRA, Diagnostic Reviews, and other assessment tools as needed. Assessment can be used for up to 2 sessions following the initial walk-in screening. Not a planned service – does not need to be on a treatment plan.

SA Treatment Plan Development (Service Code 2022): Face-to-face session with client and/or family members to develop, revise, or review a treatment plan. Specialist is encouraged to use this service code 1-2 times every 90 days to work with client on treatment goals and progress.

Explicitly state in the Progress Note that the client agrees with the plan and describe the client's participation in creating the plan.

Offer the client a copy of the TP and document whether the client accepted. Examples:

"Copy offered to client – client declined."

"Copy given to client."

Bundle time spent developing/writing the TP in Anasazi with a face-to-face or telephone service with the client. TP development in Anasazi is billable if linked to a service, but it is not a stand-alone service.

[Click here to view an example of a Plan Development Progress Note](#)

SA Crisis Intervention (Service Code 2004): Face-to-face session with client, wherein the client is at imminent risk of relapse or has relapsed, or has other immediate needs that place them at risk of relapse. This service is provided as needed and must meet the above definition in order to bill Drug Medi-Cal. Not a planned service – does not need to be on a treatment plan.

Choose the Intensity Type “C” for Crisis/Emergency in the note Service Indicator.

A common reason for disallowed crisis sessions are: failure to document the client’s relapse or imminent threat of relapse, or documentation that shows services being provided beyond stabilization of the client’s emergency situation.

Every crisis contact must be documented promptly. Documentation is an important part of quality care, especially for clients in crisis. During a crisis contact, always ask about and document risks to self or others.

Elements of a Well Written Crisis Note: A prompt, well written, and objective Crisis Intervention note is the best way to ensure quality client care and to manage risk for clients in a crisis situation.

- Presenting Problem is clearly stated. Use client quotes, when appropriate, to illustrate. When known, precipitating events and stresses are documented.
- Clinical behavioral observations are clearly stated in an objective, nonjudgmental manner.
- Clinical interventions (including consultations with others) and client response are clearly and objectively documented.
- A follow up plan is clearly stated. Examples: “Client will contact this Specialist with a phone check-in today at 4:00pm. Client planned to attend an AA/NA group tonight, and to use their list of support phone numbers if continuing to feel at risk of relapse tonight. Client will attend group tomorrow morning at 8:30am.”

[Click here to view an example of a Crisis Intervention Progress Note](#)

SA Collateral (Service Code 2003): Face-to-face with client and/or significant other(s) involved with the client (not another professional), ex. spouse, parents, friends, single family session or meeting with parents of a youth client. Collateral services are activities provided to a significant support person in a client’s life for **purpose of meeting the needs of the client** in achieving the goals of the client’s treatment plan.

Collateral Sessions can be used to determine family history & involvement with substance abuse and to help engage family members as partners in the client’s treatment plan. Family members will be invited to attend the Family Education sessions.

Meeting with another professional is not a Collateral Service. A youth’s teacher, for example, is a professional. In order to be eligible to bill Drug Medi-Cal for Collateral service, the definition above must be met.

[Click here to view an example of a Collateral Progress Note](#)

SA Discharge Planning (Service Code 2008): Face-to-face session with client during the discharge phase of treatment. Specialist uses the Diagnostic Review form (at discharge), Discharge Plan/Summary, discharge CalOMS. These are exit appointments that can occur over 1-2 sessions. The purpose is to create a post-treatment community support plan with the client, collect CalOMS discharge data, and review progress and strengths developed during the treatment episode. The process is to prepare the client for referral into another level of care, post treatment return to Recovery Support Services, or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

SA Individual Counseling (Service Code 2012): Face-to-face session with client and a Specialist. Use when none of the other individual service codes apply. Service is provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service.

[Click here to view examples of Individual Counseling Progress Notes](#)

SA Family Therapy (Service Code 2050): Must be conducted by an LPHA. Involves the family members of the client in the treatment process. **Sessions focus on the family's recovery.** The effects of addiction are far-reaching and patient's family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient's recovery as well as their own recovery can be conveyed. Family members can provide social support to the patient, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

SA Patient Education (Service Code 2051): Specialist provides research based education on addiction, treatment, recovery, and health risks associated with drug/alcohol use in an individual session.

GROUP SESSION SERVICES:

Group sessions constitute the program's primary treatment activity. Group counseling services are intended to assist clients in identifying attitudes and behaviors specifically connected to their SUD problems and provides support for positive changes in life style and recovery. In addition group counseling helps clients to address short term personal, family, educational/vocational and other problems related to substance abuse. Face-to-face contacts in which one or more Specialists treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. Evidence Based Practice Curriculum examples of motivational and problem-solving group modality include: Helping Women Recover (Covington); Helping Men Recover (Griffin); Matrix Model; Seeking Safety; Integrated Dual Diagnosis Treatment, Illness Management and Recovery, Hazelden Integrated Services, and Moral Reconciliation Therapy. These curriculums will be incorporated as needed to meet each individual client's needs. When an EBP is provided, it is important that the curriculum is followed with fidelity.

SA Group Matrix (Service Code 2030): Group process using EBP Matrix Outpatient Model. This includes Early Recovery, Relapse Prevention, and Social Support Matrix groups.

SA Group Helping Recover (Service Code 2031): Group process using EBP Helping Men/Women Recover for gender specific services.

SA Group Seeking Safety (Service Code 2032): Group process using EBP Seeking Safety for trauma based services that are gender specific.

SA Group Moral Reconciliation Therapy (Service Code 2033): Group process using EBP Moral Reconciliation Therapy for criminal thinking that is often associated with substance use disorders.

SA Group Integrated Dual Disorder Treatment (Service Code 2034): Group process using EBP Integrated Dual Disorder Treatment for Co-Occurring Disorders.

SA Group Illness Management & Recovery (Service Code 2035): Group process using EBP Illness Management &

Recovery for Co-Occurring Disorders.

SA Group Seven Challenges (Service Code 2037): Group process using EBP Seven Challenges for youth treatment.

SA Group PRIME (Service Code 2040): Group process using EBP Prime for Life or Prime Solutions curriculum.

SA New Directions (Service Code 2026): Group progress using EBP New Directions for criminogenic factors.

SA Journaling (Service Code 2041): Group process using EBP Interactive Journaling by Changes Co.

SA Group Counseling (Service Code 2011): General group process, may be topic focused, however a set EBP/Curriculum is not being used.

SA Multi-Family Group (Service Code 2015): General process group. Can be topic focused without a set curriculum, or can be several families together in a single group process using EBP (such as Celebrating Families).

[Click here to view example of Group Therapy Progress Notes](#)

EDUCATION SESSION SERVICES:

Planned, structured, didactic presentation of information related to alcohol or drug abuse.

SA HIV Education (Service Code 2016): HIV education provided individually or in a group session.

SA Education (Service Code 2009): Focus of group session is to provide education, such as DVDs, guest speakers and other information is used (not associated with a particular curriculum/ listed above).

SA Parenting Group (Service Code 2016): Focus of the group session is parenting information processed in a group to aid in the client's recovery.

SA Tobacco Cessation (Service Code 2025): Counseling in group sessions for the purpose of cessation of tobacco use.

SA Patient Education (Service Code 2053): Provide research based education on addiction, treatment, recovery and associated health risks in a group session.

INTENSIVE OUTPATIENT SERVICES:

Intensive Outpatient Treatment (ASAM Level 2.1) structured programming services are provided to beneficiaries a minimum of nine hours with a maximum of 19 hours a week for adults and a minimum of six hours with a maximum of 19 hours a week for adolescents when prescribed by a Medical Director or LPHA to be medically necessary. Services consist primarily of counseling and education about addiction-related problem. Services can be provided in-person, by telephone, via telehealth, or in any appropriate setting in the community.

SA Intensive Outpatient Treatment Perinatal (Service Code 2005): 3 hour session for pregnant or women with

children (POEG). Pregnant and post-partum women shall receive: mother and child rehabilitative services, parenting skills, training in child development, which includes cooperative child care activities. Group counseling services are provided and are intended to assist women in identifying attitudes and behaviors specifically connected to their AOD problems. In addition group counseling helps clients to address short term personal, family, educational/vocational and other problems related to substance abuse. San Luis Obispo County uses several Evidence-Based Programs in the Intensive outpatient treatment program, including: Helping Women Recover (Covington); Matrix Model; Seeking Trauma; and Parenting for Recovery. These curriculums will be incorporated as needed to meet each individual woman's needs. Education is provided on reducing the harmful effects of alcohol and drugs on the mother and fetus/children.

Cooperative child care activities are included known as Family Socialization wherein the mother and child work together to create a healthy snack and participate in a child centered play or craft activity. Drug and Alcohol Services Workers are present at all times during the child care activities to provide parenting skills coaching, to provide child development education, and to observe interactions. Additionally, a Drug and Alcohol Services Worker and at least one parent are present in the childcare room while group counseling is taking place.

Provision of transportation to and from medically necessary treatment is provided by the Drug and Alcohol Services Workers including to and from the San Luis Obispo Drug and Alcohol Services Intensive outpatient treatment program. Vans are available for the transportation services on a daily basis. Transportation to other services may also be coordinated with the Child Welfare Services Department as appropriate. Bus passes and other transportation solutions may also be used. Transportation is provided to court for Dependency Drug Court, for medical appointments, for residential placements, and for other ancillary services.

SA Intensive Outpatient Treatment (Service Code 2100): 3 hour session using an intensive outpatient program subunit.

MEDICAL & NURSING SERVICES:

DAS offers Withdrawal Management and Medication Assisted Treatment services.

Withdrawal Management: Medically monitored detoxification process. Medical necessity for Withdrawal Management must be determined/authorized by the BH Medical Director or designee, or an LPHA in accordance with the client's individualized treatment plan. DAS provides ASAM Level 1 Withdrawal Management Services, also called ambulatory withdrawal, and clients are often provided additional group treatment services conducted by the MAT team of staff members. Some of the medications used for Withdrawal Management are: Librium, Naltrexone, Buprenorphine/Suboxone. The goal of Withdrawal Management is to safely reach total abstinence (illicit drugs and medication).

The components of Withdrawal Management services are:

- **Intake:** The process of admitting a client into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
- **Observation:** The process of monitoring the client's course of withdrawal. To be conducted as frequently as deemed appropriate for the client and the level of care the client is receiving. This may include but is not limited to observation of the client's health status.

- **Medication Services:** The prescription or administration related to substance use disorder treatment services, or the assessment of the side effects or results of that medication, conducted by staff lawfully authorized to provide such services within their scope of practice or license.
- **Discharge Services:** The process to prepare the client for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

Medication Assisted Treatment: Medication Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. MAT Treatment includes the ordering, prescribing, administering, and monitoring of all medications for substance use disorders. Opioid and alcohol dependence, in particular, have well established medication options. Some of the medications used for the treatment of SUD's are: Buprenorphine/Suboxone, Naltrexone, Disulfiram (Antabuse) for example. DAS provides MAT services with clients in concurrent treatment across levels of care (Level 1.0, Level 2.1, Level 3.1).

The Components of Medication Assisted Treatment are:

- Intake
- Individual and Group Counseling
- Patient Education
- Medication Services
- Collateral Services
- Crisis Intervention Services
- Treatment Planning
- Medical Psychotherapy
- Discharge Services

Detox: For the purpose of ODS-DMC and in alignment with ASAM Criteria, detox is referred to as **Withdrawal Management**.

Withdrawal Management Service Codes:

SA DTX Medication-Opiates (Service Code 2006): SUD Service. Suboxone medication costs only. This service code is used for self-pay clients and is used by an MD, NP, LPT. Not added onto client treatment plans.

SA Detox Sessions-Opiates (Service Code 2010): SUD Service. Protocols for opiate detoxification visits (sliding scale). Face-to-face with the patient. Management of withdrawal symptoms. This service code is used by an MD, NP, LPT.

SA Detoxification-Alcohol (Service Code 2023): SUD Service. Protocols for alcohol withdrawal symptom visits (sliding scale). Face-to-face with the patient. Management of withdrawal symptoms. This service code is used by an MD, NP, LPT.

MAT Service Codes:

SA Observation (Service Code 2070): SUD Service. Face-to-face monitoring the patient's progress in medication assisted treatment and monitoring health status/issues. This service code is used by MD, NP, LPT.

SA MAT Ordering, Prescribing, and Administration of Medications (Service Code 2071): SUD Service. Ordering refills, prescribing, administering of medications for MAT (administrative and support functions associated with MAT). This service code is used by MD, NP, LPT.

SA MAT Medical Psychotherapy (Service Code 2072): SUD Service. Face-to-face discussion by the Medical Director/Physician with the patient. This service code is used by MD.

Psychotropic Medication Service Codes:

DAS offers some psychotropic medication services to clients in SUD outpatient treatment services with mild to moderate mental illness. It is most often clients receiving forensic services, post-release treatment services, co-occurring treatment, and Medication Assisted Treatment that access psychotropic medications services from DAS. In some cases, the client may be referred to their primary care provider or to Mental Health.

SA Medication Ed/Training (Service Code 2013): MH Service. Face-to-face service to provide medication, follow-up of symptoms, refill prescriptions. This service code is used by MD, NP, LPT.

SA Medication Evaluation (Service Code 2014): MH Service. Face-to-face initial assessment for the use of medications for psychiatric conditions. This service code is used by MD or NP.

Medical/Education Service Codes:

For medical and physical wellness concerns associated with SUD, patient education services can be provided in a group or individual session. Primarily provided by MD, NP, and LPT but can be provided by a DAS Specialist/Case Manager.

SA Physician Consultation (Service Code 2090): Consultation between the treatment staff and the physician for the benefit of the patient. Patient is not present. Physician consultation services may address medication selection, dosing, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. This service code is used by MD.

SA History & Physical (Service Code 2051): MD, PA, or NP conducts a face-to-face physical examination of the patient for medical conditions.

SA Naloxone Education (Individual Service Code 2084, Group Service Code 2085): Face-to-face education about Naloxone with an individual patient or in a group setting.

SA HepC Education (Individual Service Code 2086, Group Service Code 2087): Face-to-face education about HepC with an individual patient or in a group session.

MEDICATION REFILL FREQUENTLY ASKED QUESTIONS

If I get a verbal order from the MD/NP and call it in to the pharmacy, do I have to do anything else?

Yes! No matter how the prescription information gets to the pharmacy – phone, electronic transmission through SureScripts, or hand written by the MD/NP – **all** refill information **MUST** be entered in Anasazi.

Preapproving the prescription and routing it to the MD:

- Ensures that the medication information is in Anasazi for all future treatment providers to reference
- Provides the mechanism for the MD/NP to sign the order
- Protects LPT/LVN/RN staff (refill orders without an MD/NP signature = prescribing without a license!)

Do I have to have a signed Authorization to Use/Disclose PHI with the pharmacy to help get the meds refilled or to provide information for the TAR?

No, but limit the disclosure to just what is needed and log the disclosure on a BH Record of Disclosure in Anasazi.

[Click here to view an example of a Medication Support Progress Note](#)

[Click here to view the Medication Refill Workflow diagram \(Appendix S\)](#)

CASE MANAGEMENT SERVICES:

Case management services assist client's in accessing needed medical, educational, social, prevocational, rehabilitative, or other community services. Case Management services also focus on coordination of SUD treatment and integration with primary (physical health) care. Case Management services will help clients move through the system and access other needed health and ancillary services to support their recovery.

Case management services can be provided in the following settings as long as the services are affiliated with a Drug Medi-Cal certified location: Drug Medical provider sites, County locations, Regional Centers, or in other alternative settings that have been outlined and approved. Case management services can be provided via: Face-to-face, telephone, by telehealth, or anywhere in the community (however the individual providing the service must be linked to a certified site/facility). Case management can be provided by an LPHA or a Certified Counselor.

Case Management always involves an intervention on behalf of the client. Merely transporting a client to an activity and/or exchanging information with other staff (especially if the information is written in the record) are not Case Management activities because no therapeutic intervention was provided on behalf of the client.

SA Care Management (Service Code 2002): Significant time spent on phone calls, meeting with other agencies/professionals, consultation with Supervisor, record ethical concerns, reports and paperwork for other agencies (ex. Housing, disability, schools, primary care physician). Communication and coordination of the client's care.

Examples of Care Management:

- "Specialist contacted PCP to coordinate care."
- "Specialist referred client to the Holman Group for mental health services."
- "Specialist called Probation Officer (PO) and gave him an update on client's progress in treatment in the areas of..."

Note: Billable Case Management activities related to making a referral include discussing a resource with a client, contacting the resource, completing a written referral form (including the referrals within Anasazi), helping a client access the referral and following up to make sure the connection happened. A referral is considered complete when the referral source accepts responsibility for providing a service. Multiple components of a referral completed on the same day for a client may be bundled together as part of one Case Management Progress Note.

SA Individual Case Plan Development (Service Code 2080): Individual session to develop the client's case management plan that includes service activities. Comprehensive assessment and re-assessment of the client's individualized needs.

SA Patient Advocacy (Service Code 2081): Linkages to physical and mental health care, transportation and retention in health care.

SA Monitoring (Service Code 2082): Monitoring the client's progress and monitoring service delivery. Communication and coordination, follow up with client or with agencies and other professionals. May include attending team meetings.

SA Care Transition (Service Code 2083): Activities and linkages to higher or lower level of SUD care. Transferring to residential treatment or detox facilities. Transferring the client back to outpatient treatment (step down in level of care). Applications for Recovery Residences.

SA Patient Education (Individual Service Code 2052, Group Service Code 2053): Provide research based education on addiction, treatment, recovery and associated health risks in an individual or group session.

CHOOSING BETWEEN CASE MANAGEMENT AND PLAN DEVELOPMENT:

Case Management: Reading/discussing the Treatment Plan with the client or support person, monitoring progress without making changes to the Treatment Plan, or completing a transfer summary is Case Management for all clients.

Plan Development: Creating a new Treatment Plan or making any change (Revise or Review) to an existing Treatment Plan is Plan Development for all clients, including youth.

COMPLETING PAPERWORK WITH A CLIENT:

Clients often ask for help with forms and paperwork. If all you do is type or fill out a form for a client, then you are not providing a billable service because your license and/or training are not necessary to accomplish the task.

However, the services you provide while helping a client complete paperwork or access a service may be billable as Care Management. In general, if you emphasize what you did that required your specific training and professional skill, then the service you provided (linking, collaborating with or teaching the client how to access resources) may be billable. In your Progress Note, focus less on the unbillable clerical part (typing/filling out the form) and include more about your interventions and how they helped the client.

Tips for documenting paperwork completion:

- Bundle the completion of the form with a face-to-face service with the client
- Focus on the interventions you provided and how those interventions helped your client by reducing impairment or preventing deterioration
- Be specific about the symptoms would prevent the client from filling out the form independently
- Write about what might happen to the client if you don't help (i.e., deterioration, need for higher level of care)
- Indicate in your note that you are billing for the interventions, not the typing

Here is an example of a Case Management Progress Note that follows these tips:

Focus of Session:

Mary arrived for her scheduled appointment and asked this Specialist to help link her to Housing Authority of San Luis Obispo. Mary reports that she is losing her housing in two months and she is worried that this will place her sobriety in jeopardy if she loses this structured part of her life. Mary's worry around this issue includes a high degree of disorganization and prevents her from completing the application or accessing community resources on her own. Without assistance, she is highly likely to deteriorate to the point that a higher level of care.

Clinical Decisions/Interventions:

*Helped Mary identify needed resources and supports
 Discussed the importance of action (versus passivity) to reduce her worry
 Reminded Mary of her treatment gains and successes
 Prompted her to use her coping skills to reduce level of distress in session
 Assisted her in formulating answers and completing application
 Helped Mary develop a plan for managing anxiety while waiting for response to her application
 Typed and electronically filed her application (15 minutes, not billed)*

[Click here to view an example of a Case Management Progress Note](#)

RECOVERY SUPPORT SERVICES:

Recovery services are important to the client's recovery and wellness. As clients complete treatment, they are connected to recovery support services to build connections within the recovery community and to develop self-management strategies to prevent relapse. Clients may access medically necessary recovery services after their course of treatment. Recovery services are available to clients whether they have relapsed, been triggered, or as a preventative measure to prevent relapse.

As part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and during the transfer/transition planning process, clients will be linked to applicable recovery services. The treatment community becomes a therapeutic agent through which clients are empowered and prepared to manage their health and health care. Therefore, treatment must emphasize the clients central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to patients. Services are provided as medically necessary.

Recovery services can be provided via face-to-face contact, by telephone, telehealth, or in the community (as long as the provider delivering the services is linked to a certified Drug Medi-Cal facility such as DAS). Recovery

services can be provided by at LPHA, Certified Counselor, or Peers (for SA Substance Abuse Assistance service).

SA Self-Help Meetings (Service Code 2021): Way to record 12 Step and other required self-help meetings. Linking client to self-help and support, spiritual and faith-based support.

SA Socialization (Service Code 2024): Activities designed to improve client social skills (such as outings, graduation, potlucks, movie nights, sport events).

SA Recovery Monitoring (Service Code 2060): Recovery coaching and monitoring via telephone, telehealth or internet.

SA Substance Abuse Assistance (Individual Service Code 2061, Group Service Code 2062): Peer-to-peer services and relapse prevention. Service conducted by a person with lived experience on an individual or group basis.

SA Education & Job Skills (Individual Service Code 2063, Group Service Code 2064): Linking a client to life skills, employment services, job training, and educational services on an individual or group basis.

SA Family Support (Individual Service Code 2065, Group Service Code 2066): Linking a client to childcare, parent education, Celebrating Families Groups, child development support services, family/marriage education. Service conducted on an individual or group basis.

SA Individual Recovery Plan Development (Service Code 2067): Individual session to assess and develop the client's recovery plan.

SA Ancillary Services (Service Code 2068): Linking a client to housing, transportation, and case management.

SA Individual Counseling (Service Code 2012): Face-to-face session with client and a Specialist. Use when none of the other individual service codes apply. Service is provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service.

SA Group Counseling (Service Code 2011): General group process, may be topic focused, however a set EBP/Curriculum is not being used.

[Click here to jump to the Anasazi Service Code Definitions Appendix J](#)

✧ .5 Level of Care - Diagnosis vs. No Diagnosis ✧

DAS provides clients at risk of developing a SUD or those with an existing SUD screening, brief treatment as medically necessary, and when indicated, a referral to treatment with a formal linkage. It is determined during the screening and assessment sessions whether the client meets medical necessity for treatment (subunit reads "Adult ASAM Level .5 Meets Medical Necessity"), or that the client does not meet medical criteria (subunit reads "Adult ASAM Level .5 No Medical Necessity").

There are fewer documentation requirements for a client that does not meet medical necessity (as the services will not be billed to Drug Medi-Cal).

[Click here to jump to Appendix G for the ASAM .5 Decision Tree.](#)

✧ Continuing Services ✧

90 DAY TREATMENT PLAN REVIEW

The client's treatment plan is updated every 90 Days following the start date of the first SA Treatment Plan. In the 30 days before the treatment plan is due, the Specialist and client meet for 1-2 treatment planning sessions to review goals and objectives, making changes and entering updates as applicable. Follow instructions in the treatment planning section of this document as to treatment timelines and signatures.

TREATMENT PLAN REVIEW TIPS

- Target dates are updated for focus of treatment, goals, and objectives.
- Goals and objectives are updated as the client progresses or regresses in treatment.
- Medical goal and objective(s) are updated to report upon the client's completion of their physical exam or other medical/dental needs.
- Intervention (service) frequency is updated.

EXTENDED JUSTIFICATIONS

On a six month basis, when planning to continue treatment with a client (every other treatment plan), the Specialist will need to document the justification for continuing Drug Medi-Cal treatment services on the Justification to Continue Treatment Services assessment form. This form is to be filled out by the Specialist no sooner than 5 months and no later than 6 months from admission or the date of the last justification.

SECTIONS OF THE EXTENDED JUSTIFICATION FORM:

1. **Date of Admission:** Date of Walk-In Screening.
2. **Client Continues to Meet Eligibility Requirements to Receive Treatment:** Specialist must answer Yes/No and may choose a specifier if applicable.
3. **Clients Progress in Treatment During the Last Six (6) Months:**
 - a. Alcohol/Other Drugs: How has client done in treatment during the last six months? What measurable evidence can be provided (drug tests, progress towards substance use goals on treatment plan, attendance)?
 - b. Client Physical: Specialist must document if the client has completed their physical exam. If the client has not obtained an exam, Specialist documents their attempts to support the client in reaching this goal.
 - c. Medical: What medical issues is the client currently addressing while in treatment?

- d. Legal: What is the client's current legal status and are there any new legal issues? Include narrative about CWS cases.
- e. Family/Social/Relationships: How is the client making progress/regression towards improved family and social relationships?
- f. Education/Employment/Financial/Support: How is the client moving towards structure and independence? What are the barriers?
- g. Psychiatric: How is the client's current emotional/behavioral health? Have referrals been made for mental health care? Medications being taken?

4. Prognosis and Explanation of Prognosis: Specialist must provide a prognosis and an explanation of the prognosis.

5. Justification to Continue Services: Specialist must provide a narrative as to why the continuation of treatment services is necessary and medically indicated. Narrative must be individualized, and should include discussion about level of care changes/progress, and current stage of change. Narrative can discuss potential consequences should treatment services end.

EXTENDED JUSTIFICATIONS FREQUENTLY ASKED QUESTIONS

Where do I find the Extended Justification form in Anasazi?

The Extended Justification is an assessment form which can be found in the assessment menu (SACTJ – SA Justification Continue Tx). Create the assessment with the date that the assessment took place, no sooner than 5 months and no later than 6 months from admission or the date of the last justification. The Specialist's signature must also occur between the 5th and 6th month of treatment.

What information is critical to document on the extended justification?

It is imperative that every question on the assessment is answered (there must be no blank sections). However, if there is nothing to note in a section, for example, legal, state that this area is not applicable and why ("Client does not currently have any legal issues.") The Specialist must document the reason why the Client must remain in medically necessary services. Some examples for justification may include: still using drugs and/or alcohol, limited social support, upcoming transitions of living, employment, family, long history of relapse, etc.

What signatures are required on the Extended Justification?

The Specialist indicates and reviews the progress and eligibility of the client to continue services. The Specialist assigns the Program Supervisor or LPHA to this form for signature.

What happens the Extended Justification is not done on time?

There is a potential for lost billing if an extended justification is not complete to justify the client's continued Drug Medi-Cal treatment services.

CalOMS ANNUAL UPDATE

Once a client has been in treatment services for a period of one year, a CalOMS annual update must be completed. The form is found in the assessment menu (CALAUPD – CalOMS Adult Update or CALYUPD – CalOMS

Youth Update). The information requested on the form is brief and includes alcohol/drug use in the last 30 days, arrests in last 30 days, school, pregnancy, and mental health information. Please follow signature instructions for the CalOMS included in the admission section of this guideline manual. The CalOMS type (1, 2, 3) at admission must match the type chosen for the annual update.

✧ Closings & Discharge Plan/Summary ✧

When a client is discharged from the Program, an updated Diagnostic Review (if necessary), Discharge Plan/Summary, Discharge CalOMS, and any other final entries in the client EHR are completed within thirty days. After review by the Program Supervisor, the EHR is closed. San Luis Obispo Drug and Alcohol Services maintain client records for not less than seven years after discharge.

NOTICE OF INTENDED ACTION

If a client has dropped out of services, a Notice of Intended Action must be sent to the client at least 10 calendar days prior to the effective date that the client will be discharged from treatment services. This letter includes the rights of the client to appeal their discharge status, offers additional referrals, and encourages the client to return to services should that be needed.

FINAL CLOSING WORKSHEET

A final closing worksheet is used for each closing all DAS subunits and sending the physical record to storage. The form is used as a worksheet for the Specialist to move through the closing process and is delivered to the AA at the clinic site location who will transfer the chart to HIT for verification and final close of the physical chart.

UPDATE DIAGNOSTIC REVIEW (IF NECESSARY)

It may be necessary to update the client's diagnosis at discharge if there is a change to the diagnosis. Progress can be documented in a number of ways including: change of diagnosis to a substance use disorder in remission, end date of a diagnosis, end date of psychosocial/contextual factors. Regression may also be documented in a number of ways including: change of diagnosis severity, addition of other diagnosed disorders, changes to the medical section and to the psychosocial/contextual factors. It is very important to make sure that the diagnosis is correct at discharge so that progress can be tracked and information available to next treating provider should the client return to services.

For many cases, the diagnostic review would not be updated such as when a client is open/close (not in treatment for a long enough length of time to know information about progress or regression) or when there is no change to the diagnosis.

The diagnostic review must be final approved before a discharge plan or discharge summary is launched, as the diagnosis is attached to the summary/plan assessment.

DISCHARGE STATUS

San Luis Obispo Drug and Alcohol Services has discharge procedures defining the criteria for successful completion of the program, unsuccessful discharge, involuntary discharge, transfers and referrals. The specific discharge code/reason chosen for the close of the client's chart must match on the Discharge Plan/Summary, Discharge CalOMS, and Subunit Close Reason.

Code	Reason	Type of Discharge
1	SA Completed TX Ref	Standard
2	SA Completed TX Not Referred	Standard
3	SA Quit Sufficient Progress Ref	Standard
4	SA Quit Sufficient Progress Not Ref	Administrative
5	SA Quit Inadequate Progress Ref	Standard
6	SA Quit Inadequate Progress No Ref	Administrative
7	Deceased	Administrative
8	Discharged/transferred to jail	Administrative

DISCHARGE PLAN VS. DISCHARGE SUMMARY (SA OPDC SUMMARY)

The concluding entry in each client EHR is the Discharge Plan/Summary. The Discharge Plan/Summary is an overall description of the treatment episode, the reason for discharge, the client's plan for ongoing post-treatment support, and any referrals made by program staff. In addition, the Discharge Plan/Summary contains a description of the client's current status at the time of discharge in the following areas: alcohol and other drug use, vocational or educational achievements, completion of physical examination, and legal status. When writing a Discharge Plan or Discharge Summary, it is dated with the last face-to-face contact with a Specialist for an individual or group service. Drug testing does not account as a last face-to-face contact because it was not with a Specialist.

The Discharge Plan/Summary must both contain the following elements:

- The duration of the client's treatment based on the admission and discharge dates.
- The reason for discharge.
- A narrative summary of the treatment episode.
- The client's prognosis.
- Current drug or alcohol usage.
- Vocational/educational achievements.
- Criminal activity.
- Referrals.

Discharge Plan:

A Discharge Plan is chosen on the SA OPDC Summary when a client has a planned termination from treatment. The Specialist summarizes treatment and documents any discussions regarding closing with client, Psychiatrist,

Program Supervisor, or MH (if applicable) on the Discharge Plan. The Discharge Plan must be completed as fully as possible within 30 days prior to the date of the last face-to-face treatment contact with the client.

The discharge plan includes a client's relapse triggers and a plan to assist the client to avoid relapse when confronted with triggers. It also includes activities and referrals that will help the patient continue to work on long terms goals identified in the treatment plan.

Discharge Planning is a Drug Medi-Cal reimbursable individual service. The Specialist creates a progress note with the individual service session code 2008 "Discharge Planning." Two discharge planning sessions can be billed during the 30 days prior to the clients planned discharge. While discharge planning may occur over two sessions, the Discharge Plan is created with and signed on the final day of services (date of last face-to-face contact with a Specialist).

Discharge Summary:

For any client that the Specialist has lost contact with, a Discharge Summary is chosen on the SA OPDS Summary. The Discharge Summary is completed within 30 days of the Specialist's last face-to-face contact with the client. The Discharge Summary must include the reason for discharge, dates of treatment episode, narrative of the treatment episode, and a statement about the client's prognosis.

Contact attempts with the client can be documented on the Discharge Summary, especially if the TP is expired. Do not add an ISL for entering progress notes when attempting to contact the client prior to closing, because if the ISL is mistakenly left open, then services contained in it are disallowed.

Note: Writing a Discharge Summary is not a billable service – no Progress Note is required. However, if you are meeting with a client for a planned discharge, then "Discharge Planning" is billed as an individual service as covered above.

SECTIONS OF THE DISCHARGE PLAN/SUMMARY FORM:

1. Choose Discharge Summary or Discharge Plan.

- a. Based on the choice made, the sections that the Specialist must complete will remain white and others will gray out.

2. Description of the Treatment Episode (Duration of treatment with admission date and discharge date, narrative summary of the treatment episode, describe services received and the client's response by ASAM Dimension):

- a. Date of the assessment must be the date of the final face-to-face contact with a Specialist (cannot be a drug test date or the date the report is being written).
- b. Include treatment episode begin date and episode end date (last day of face-to-face contact). DMC requires the duration of the treatment episode be included.
- c. Narrative summary must be individualized as to how the client progressed/regressed in treatment by ASAM Dimension. Text template is available.

3. Prognosis:

- a. Specialist must choose a prognosis radial button.

4. Explanation of Prognosis:

- a. Specialist must provide a narrative.

5. Current alcohol and/or other drug use:

- a. Specialist must update the MEW by adding additional substance(s) and/or changing the use information for each substance.

6. Current medications prescribed by Behavioral Health staff Including dosage and response, plan for continued medication following discharge or other medical issues:

- a. Specialist must enter medications prescribed by BH staff. Medication information can be found on the medication tab on the client's EHR.
- b. Specialists may use this field to note prescriptions prescribed by other providers by clearly naming the provider.
- c. Specialists may use this field to note medical items of importance if necessary and relevant to the discharge.

7. Vocational and educational achievements (achievements, no changes, scheduling structured time such as volunteering, caring for family):

- a. Specialist must provide a narrative.

8. Legal Status:

- a. Specialist must choose a legal status from the drop down menu.

9. Legal Status Comments:

- a. Specialist must enter in a narrative regarding the client's legal status or enter "N/A."

10. Current Living Situation: (status at discharge, recovery environment support).

- a. Specialist must enter narrative.

11. Reason for Discharge:

- a. Specialist must chose a discharge reason (this discharge reason must match the close assignment reason).

12. Discharge Summary Comments (for close reasons 5, 6, 7, 8). Narrative for discharge reason, collaboration with other agencies regarding close, transfers and referrals, recommendations for futures services including other levels of care:

- a. Narrative required if a Discharge Summary.
- b. This will be the end of the Discharge Summary (fields below do not apply and will gray out).

13. Discharge Plan Comments (for close reasons 1, 2, 3, 4). Narrative for discharge reason, collaboration with other agencies regarding close, transfers and referrals, recommendations for futures services including other levels of care:

- a. Narrative required if a Discharge Plan.

14. Client's relapse triggers and plan to assist client to avoid relapse when confronted with each trigger.

- a. Narrative required if a Discharge Plan.

15. Client's Discharge/Support Plan for Continued Recovery and Client Comments at Close of Treatment.

- a. Narrative required if a Discharge Plan.

16. Client was provided with a copy of their Discharge/Support Plan

- a. Specialist must choose answer and provide narrative explanation if "No" is chosen.

17. Other General Tips:

- a. A client that is successfully discharged would probably not have a substance in the MEW that is noted as having been used in the last 30 days (number should be 0).
- b. No field should be blank (with the exception of those that gray out).
- c. If a client was AWOL, did the Specialist document attempts to contact the client by phone to re-engage them in services?

DISCHARGE FREQUENTLY ASKED QUESTIONS:

If a client came for walk-in screening, but did not attend any treatment services (ex. assessment, group), what closing paperwork do I need to complete?

If client becomes absent following a walk-in screening, and contact cannot be established, as long as a treatment subunit was NOT opened, then an SA OPDC Summary & a closing CalOMS is not needed.

When is a discharge plan due?

The discharge plan is signed at the last face-to-face contact date with the client, although it can be created and worked on with the client in the 30 days prior to close.

When is the discharge summary due?

The discharge summary, for a client who has been out of contact with the Specialist and is not attending services, is due within 30 days of the last face-to-face contact with a Specialist.

DISCHARGE CalOMS

At discharge, the Specialist will complete a discharge CalOMS. The form is found in the assessment menu (CALADSCH – CalOMS Adult Discharge or CALYDSCH – CalOMS Youth Discharge). The information requested on the form is brief and includes alcohol/drug use in the last 30 days, arrests in last 30 days, school, pregnancy, and mental health information. Please follow signature instructions for the CalOMS included in the admission section. The CalOMS discharge type (1, 2, or 3) must match the opening CalOMS type.

FREQUENTLY ASKED DISCHARGE CALOMS QUESTIONS

What should I date the discharge CalOMS assessment?

The date of the discharge CalOMS must match the date that the assignment to the treatment subunit is closed. The discharge reason for the assignment and the CalOMS must also match. (This will not necessarily be the same date as the OPDC Summary/Plan which occurs on the last date of face to face contact).

✧ Transfer Between Clinics or Programs ✧

Whenever a client's care transfers from one clinic (unit) to another or to another level of care, steps must be taken to ensure continuity of care. There are 4 types of transfers:

Non admit Client Transfer: Drug and Alcohol Services facilitates the transfer of client's treatment between in county providers sites. When clients are placed on a walk-in sub-unit with no intake paperwork completed they are not considered officially admitted to treatment. When a clinician screens a client and deems that they would be better suited to receive services at another clinic a specific procedure must be followed.

Change in Treatment Modality Non-Transfer: Drug and Alcohol Services facilitates the transfer of clients between different types of treatment modalities within the same clinic. Drug and Alcohol currently has two active types of treatment modalities Intensive Outpatient Services and Outpatient Services. Clients will move from different treatment modalities based on client's need for an increase in frequency of services or decrease in frequency of services based on progress in treatment.

Transfer of Client Treatment between Clinics: Drug and Alcohol Services facilitates the transfer of client's treatment between in county providers. The can included any of the following: when a client is moving within the county, when the client requests to be transferred to another clinic, or to facilitate a client's need for culturally appropriate services within a setting.

Transfer of Client to a Different Treatment Modality: Drug and Alcohol currently has two active types of treatment modalities Intensive Outpatient Services and Outpatient Services. Clients will move from different treatment modalities based on client's need for an increase in frequency of services or decrease in frequency of services based on progress in treatment. This may mean a transfer to another clinic; however it also may mean the client will continue services at the same clinic but the type of service at the clinic has changed (see non-transfer above).

All 4 types of transfers have a policy and procedure to ensure the client's continuity of care. There are duties assigned to the Assessment Coordinator and/or Program Supervisor, Transferring Specialist and Receiving Specialist.

[Click here to move to Appendix P for Transfer Policy & Procedures](#)

✧ Special Documentation Scenarios ✧

Scenario:	Explanation:	Instructions:
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Outpatient services for a client who is at Jail/PHF (not JSC)	When a client is incarcerated or at inpatient <u>psychiatric</u> hospital, outpatient SUD services are not usually billed.*	Write a Progress Note using the appropriate service code for the intervention performed. Select the <u>Place of Service</u> (correctional facility, inpatient psychiatric facility). Include the service time. No bill will be generated.
Client is at JSC	The <u>Place of Service</u> for Juvenile Hall is Y.	For clients in JSC, the Unit is always 5719.
There is No valid Treatment Plan		If there is no Treatment Plan, contact the client to start developing a plan.
Second Opinions	Second opinions always involve an assessment, a review of an assessment by a LMFT or LCSW, or an evaluation by a psychiatrist.	Write a Progress Note using the appropriate service code for the intervention performed. For <u>Billing Type</u> , select "Second Opinion". No bill will be generated, and the client is never charged for the service.
Spanish-language Interpretation Services		<p>If a bilingual staff member conducts a service in Spanish, use <u>Contact Type</u> P (Telephone Spanish) or S (Face-to-Face Spanish).</p> <p>When a Spanish-speaking staff member or other interpreter is asked to join a session, the translator is not a collateral server. Use <u>Contact Type</u> P (Telephone Spanish) or S (Face-to-Face Spanish), because the service was provided in Spanish.</p>

✧Appendix A Flow Sheet for Drug Medical Service Documentation✧

Initial Screening = Admission Date

BH Screening Form

- Dated with Screening Date
- Signed By: LPHA/Program Supervisor

Diagnostic Review (Tentative)

- Dated with Screening Date
- Signed By: LPHA & Program Supervisor

Initial Treatment Plan

- Dated with Screening Date
- Signed By: LPHA or Certified Counselor



Admission Procedures

SUD Assessment

- Dated with Assessment Date
- Signed By: LPHA & Program Supervisor

Admission CalOMS

- Dated with Screening Date
- Signed By: LPHA or Certified Counselor & HIT Staff

Treatment Plan

- Review & Revise Diagnostic Review as necessary.
- Must Be Completed Within 30 Days of Admission
- Signed By: LPHA or Certified Counselor & Program Supervisor



Continued Services

Treatment Plans

- Review & Revise Diagnostic Review as necessary.
- Must Be Completed Every 90 Days
- Signed By: LPHA or Certified Counselor & Program Supervisor

Extended Justification

- Cannot Be Done Before 5th Month of Treatment
- Must Be Created and All Signatures Completed By 6th Month from the Admission Date
- Signed By: LPHA or Certified Counselor & Program Supervisor

CalOMS Update

- Necessary if Client in Services for 1 year
- Signed By: LPHA or Certified Counselor & HIT Staff



Discharge Procedure (Complete In Left To Right Order)

Update Diagnostic Review

- Only if Change to Diagnosis
- Signed By: LPHA & Program Supervisor

Discharge Plan OR Discharge Summary

- Signed By: LPHA or Certified Counselor & Program Supervisor

Discharge CalOMS

- Must Be Dated Same Date as Assignment Close Date
- Signed By: LPHA or Certified Counselor & HIT Staff

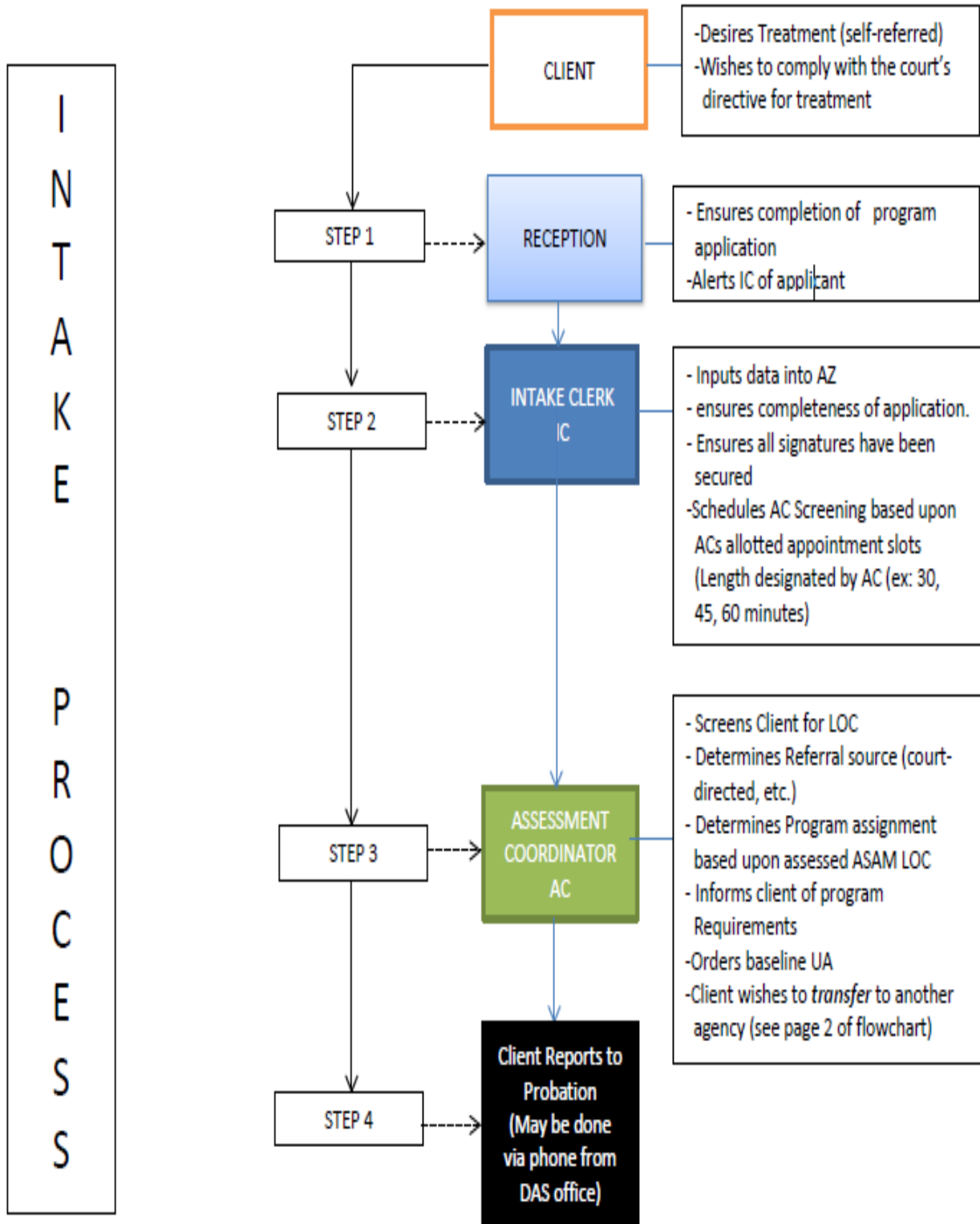
Appendix B Standard Abbreviations

A.A.	Alcoholics Anonymous	CWS	Child Welfare Services
acct	account	D/O	disorder
ADHD	Attention Deficit Hyperactivity Disorder	DAS	Drug and Alcohol Services
adj.	adjustment	dbl	double
ADL	Activities of Daily Living	DBT	Dialectical Behavioral Therapy
AG	Arroyo Grande	DC'd	discharged or discontinued
AH	Auditory Hallucinations	DD	developmentally disabled
appt.	appointment	DOB	date of birth
APS	Adult Protective Services	DSS	Department of Social Services
ASAP	as soon as possible	DUI	driving under the influence
ASH	Atascadero State Hospital	DV	domestic violence
assmt	assessment	Dx	diagnosis
AT	Atascadero	ED	emergency department
avg	average	EMR	electronic medical record
AWOL	absent without leave	ER	emergency room
B.I.D.	2 times per day	ETOH	alcohol
B/D/F	Black divorced female	Eval	evaluation
B/D/M	Black divorced male	F/U	follow up
b/f	boyfriend	Fa	father
B/M/F	Black married female	Fam	family
b/o	because of	FCN	Family Care Network
B/P	blood pressure	FoBro/FaSis/FoM	
b/u	broke up	o	Foster Brother, Sister, Mother, Father
BAL	blood alcohol level	Freq	frequency
bro	brother	FSP	Full Service Partnership
c/o	complained of	FTS	failed to show
Cauc	Caucasian	g/f	girlfriend
CBT	Cognitive Behavioral Therapy	g/u	grew up
CHC	Community Health Center	GAF	Global Assessment Functioning
cigs	cigarettes	GB	Grover Beach
Clt	client	GrGraFa	great grandfather
CM	case manager	GrGraMo	great grandmother
Co	County	group tx	group therapy
COD/CD	Co-Occurring Disorders	Grp	group
COE	County Office of Education	h/o	history of
Collat	collateral	halluc	hallucination
Coord.	coordination (as in coordination team)	HBP	high blood pressure
CPR	cardiopulmonary resuscitation	HI/SI	homicidal ideation/suicidal ideation
C-Section	caesarean section	Hisp	Hispanic

HIV	human immunodeficiency virus	OD	overdose
HS	at bedtime	OH	olfactory hallucination
Hx	history	op	operation
IEP	individual education plan	OP	outpatient
IOT	Intensive Outpatient Treatment	oriented x3	oriented by person, place, date
irreg	irregular	os	mouth
L/M	left message	P	after
LCSW	Licensed Clinical Social Worker	P/C	phone call
lg	large	Paso	Paso Robles
LMFT	Licensed Marriage and Family Therapist	PCP	angel dust/phencyclidine
LO	Los Osos	PCP	primary care physician
LPHA	Licensed Practitioner Healing Arts	Pd	paid
LPT	Licensed Psychiatric Technician	PD	Police Department
LPT	Licensed Psychiatric Technician	PDD	Pervasive Developmental Disorder
LVN	Licensed Vocational Nurse	PHF	Psychiatric Health Facility
M.H.	mental health	PHI	protected health information
M/C	Medi-Cal	PHN	Public Health Nurse
max	maximum	PI	paranoid ideation
MB	Morro Bay	PO	Probation Officer
Med Eval	medication evaluation with M.D.	po	by mouth
Med Hx	medical history	pre	before
meds	medicine; medication	prep	preparation
Meth	methamphetamine	PRN	as needed
MH	mental health	Prob	SLO County Probation Department
MHS	mental health services	prog	program
Min/Min.	Minimum/Minute	PRTS	Post Release Treatment Services
misc	miscellaneous	Psych	psychiatric
MJ	marijuana	Pt	patient
mo	month(ly)	PTSD	Post-Traumatic Stress Disorder
Mo	Mother	pvt	private
Mod	moderate	QAM	in the morning
MR	medical record	QD	daily
MRI	magnetic resonance imaging	QHS	at hour of sleep
MRT	Moral Reconciliation Therapy	QID	4 times per day
MS	multiple sclerosis	QPM	in the afternoon
MSE	Mental Status Exam	qt	quart
mtg	meeting	R/O	rule out
NOA	notice of action	Rec	recommend
NOS	not otherwise specified	reg	regular
NP	nurse practitioner	Rehab	rehabilitation
NP	Nipomo	rel	relationship
O.A.	Overeaters Anonymous	Res. Tx.	residential treatment
OCD	obsessive compulsive disorder	Ret'd	returned

Rm	room	STI	sexually transmitted infection
RN	Registered Nurse	StMo	stepmother
RTC	return to court	StSis	stepsister
Rx	prescription	sub	substitute
S/H/M	single hispanic male	SUD	Substance Use Disorder
S/W/F	single white female	sup grp	support group
SA	suicide attempt	Surg	surgery, surgeon
SAFE	Systems Affirming Family Empowerment	SVRMC	Sierra Vista Regional Medical Center
SAI	Single Accountable Individual or Primary	SWCounselor/Therapist	social worker
SC MH	South County Mental Health Clinic	Sx	symptoms
sched appt	schedule appointment	T/C	telephone call
Schiz	schizophrenia	TAY	transitional age youth
SDI	state disability insurance	TBI	traumatic brain injury
SE	side effect	tbsp	tablespoon
sec	second, secondary	TCCH	Twin Cities Community Hospital
SED	serious emotional disturbance	TD	tardive dyskinesia
SI	suicidal ideation	Temp	temperature
sib	sibling	THC	Marijuana
SIDS	sudden infant death syndrome	THPP	Transitional Housing Program
sis	sister	Thx	therapist
sit	situation	TMHA	Transitions Mental Health Assn.
SLCUSD	San Luis Coastal Unified School District	TMJ	tempo mandibular joint disorder
SLO MH	San Luis Obispo Mental Health Clinic	tox	toxicology
SLOCO	San Luis Obispo County	trans	transfer
SLOPD	San Luis Obispo Police Department	tsp	teaspoon
SLOSD	San Luis Obispo Sheriff's Department	Tx	treatment
sm	small	UA	urine analysis
SMHS	Specialty Mental Health Services	unk	unknown
SNF	skilled nursing facility	UR	utilization review
SO	significant other	UTI	urinary tract infection
SOC	share of cost	w/	with
Soc.	socialization	w/d	withdrawn
Soc. Serv.	social services	w/o	without
Spx	specialist	wk.	week
SSA	Social Security Administration	WNL	within normal limits
SSD	Social Security Disability	work comp	Workers' Compensation
SSI	Supplemental Security Income	y/o	year(s) old
StBro	stepbrother	yr.	year
StFa	stepfather	YS	Youth Services
StFam	stepfamily	YTP	Youth Treatment Program (TMHA)

✧Appendix C Intake Process Diagram✧



✧Appendix D DSM 5 Included Codes✧

ICD 10 Code	ICD 10 Code Descriptions
F1010	Alcohol abuse, uncomplicated
F10120	Alcohol abuse with intoxication, uncomplicated
F10129	Alcohol abuse with intoxication, unspecified
F1020	Alcohol dependence, uncomplicated
F1021	Alcohol dependence, in remission
F10220	Alcohol dependence with intoxication, uncomplicated
F10229	Alcohol dependence with intoxication, unspecified
F10230	Alcohol dependence with withdrawal, uncomplicated
F10239	Alcohol dependence with withdrawal, unspecified
F10920	Alcohol use, unspecified with intoxication, uncomplicated
F10929	Alcohol use, unspecified with intoxication, unspecified
*F1110	*Opioid abuse, uncomplicated
F11120	Opioid abuse with intoxication, uncomplicated
F11129	Opioid abuse with intoxication, unspecified
F1120	Opioid dependence, uncomplicated
F1121	Opioid dependence, in remission
F11220	Opioid dependence with intoxication, uncomplicated
F11229	Opioid dependence with intoxication, unspecified
F1123	Opioid dependence with withdrawal
F1190	Opioid use, unspecified, uncomplicated
F11920	Opioid use, unspecified with intoxication, uncomplicated
F11929	Opioid use, unspecified with intoxication, unspecified
F1193	Opioid use, unspecified with withdrawal
F1210	Cannabis abuse, uncomplicated
F12120	Cannabis abuse with intoxication, uncomplicated
F12129	Cannabis abuse with intoxication, unspecified
F1220	Cannabis dependence, uncomplicated
F1221	Cannabis dependence, in remission
F12220	Cannabis dependence with intoxication, uncomplicated
F12229	Cannabis dependence with intoxication, unspecified
F1290	Cannabis use, unspecified, uncomplicated
F12920	Cannabis use, unspecified with intoxication, uncomplicated
F12929	Cannabis use, unspecified with intoxication, unspecified
F1310	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F13120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F13129	Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
F1320	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F1321	Sedative, hypnotic or anxiolytic dependence, in remission
F13220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified
F13230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
F1390	Sedative, hypnotic or anxiolytic use, unspecified, uncomplicated
F13920	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, uncomplicated

ICD 10 Code	ICD 10 Code Descriptions
F13921	Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium
F13929	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, unspecified
F13930	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, uncomplicated
F13939	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, unspecified
F1410	Cocaine abuse, uncomplicated
F14120	Cocaine abuse with intoxication, uncomplicated
F14129	Cocaine abuse with intoxication, unspecified
F1420	Cocaine dependence, uncomplicated
F1421	Cocaine dependence, in remission
F14220	Cocaine dependence with intoxication, uncomplicated
F14229	Cocaine dependence with intoxication, unspecified
F1423	Cocaine dependence with withdrawal
F1490	Cocaine use, unspecified, uncomplicated
F14920	Cocaine use, unspecified with intoxication, uncomplicated
F14929	Cocaine use, unspecified with intoxication, unspecified
F1510	Other stimulant abuse, uncomplicated
F15120	Other stimulant abuse with intoxication, uncomplicated
F15129	Other stimulant abuse with intoxication, unspecified
F1520	Other stimulant dependence, uncomplicated
F1521	Other stimulant dependence, in remission
F15220	Other stimulant dependence with intoxication, uncomplicated
F15229	Other stimulant dependence with intoxication, unspecified
F1523	Other stimulant dependence with withdrawal
F1590	Other stimulant use, unspecified, uncomplicated
F15920	Other stimulant use, unspecified with intoxication, uncomplicated
F15929	Other stimulant use, unspecified with intoxication, unspecified
F1593	Other stimulant use, unspecified with withdrawal
F1610	Hallucinogen abuse, uncomplicated
F16120	Hallucinogen abuse with intoxication, uncomplicated
F16129	Hallucinogen abuse with intoxication, unspecified
F1620	Hallucinogen dependence, uncomplicated
F1621	Hallucinogen dependence, in remission
F16220	Hallucinogen dependence with intoxication, uncomplicated
F16229	Hallucinogen dependence with intoxication, unspecified
F1690	Hallucinogen use, unspecified, uncomplicated
F16920	Hallucinogen use, unspecified with intoxication, uncomplicated
F16929	Hallucinogen use, unspecified with intoxication, unspecified
F1810	Inhalant abuse, uncomplicated
F18120	Inhalant abuse with intoxication, uncomplicated
F18129	Inhalant abuse with intoxication, unspecified
F1820	Inhalant dependence, uncomplicated
*F1821	*Inhalant dependence, in remission
F18220	Inhalant dependence with intoxication, uncomplicated
F18229	Inhalant dependence with intoxication, unspecified

ICD 10 Code	ICD 10 Code Descriptions
F1890	Inhalant use, unspecified, uncomplicated
F18920	Inhalant use, unspecified with intoxication, uncomplicated
F18929	Inhalant use, unspecified with intoxication, unspecified
F1910	Other psychoactive substance abuse, uncomplicated
F19120	Other psychoactive substance abuse with intoxication, uncomplicated
F19129	Other psychoactive substance abuse with intoxication, unspecified
F1920	Other psychoactive substance dependence, uncomplicated
F1921	Other psychoactive substance dependence, in remission
F19220	Other psychoactive substance dependence with intoxication, uncomplicated
F19229	Other psychoactive substance dependence with intoxication, unspecified
F19230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19239	Other psychoactive substance dependence with withdrawal, unspecified
F1990	Other psychoactive substance use, unspecified, uncomplicated
F19920	Other psychoactive substance use, unspecified with intoxication, uncomplicated
F19929	Other psychoactive substance use, unspecified with intoxication, unspecified

✧Appendix E DSM 5 Remission Codes✧

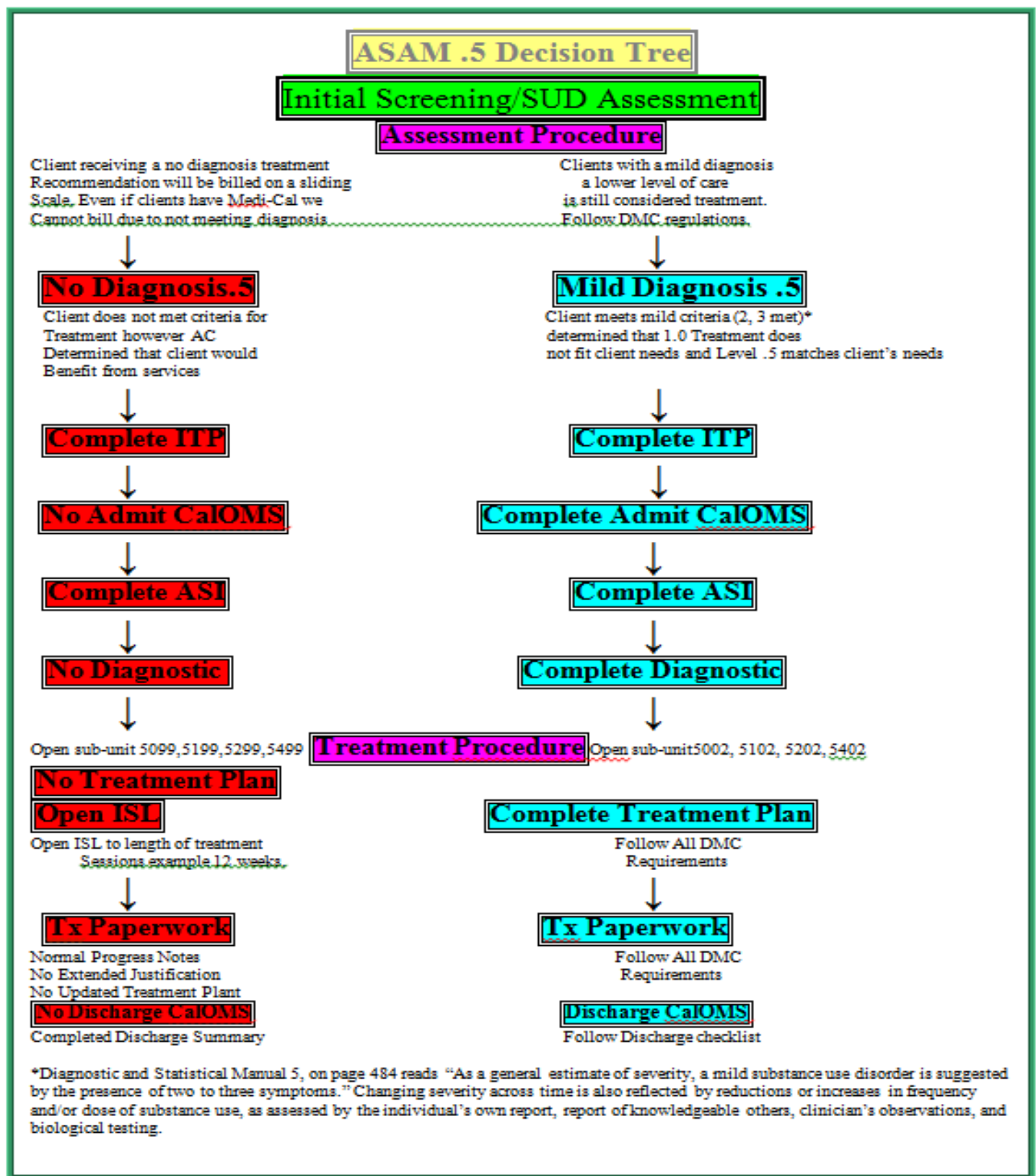
- F10.21 Alcohol dependence, in remission
- F11.21 Opioid dependence, in remission
- F12.21 Cannabis dependence, in remission
- F13.21 Sedative, hypnotic or anxiolytic dependence, in remission
- F14.21 Cocaine dependence, in remission
- F15.21 Other stimulant dependence, in remission
- F16.21 Hallucinogen dependence, in remission
- F18.21 Inhalant dependence, in remission
- F19.21 Other psychoactive substance dependence, in remission

To use one of these diagnoses, add the remission diagnosis with the current date, and end date the active substance use disorder with the day before.

✧Appendix F CalOMS Cheat Sheet ✧

This section is under construction.

✧Appendix G ASAM .5 Decision Tree✧



✧Appendix H Youth Clients✧

Youth Signature on TP Summary Table:

Minor ≥ 12, mature enough to participate in treatment planning independently:		
	Capable of treatment planning, but not minor consent services	Minor Consent services (Supervisor approval required)
Minor's Signature:	Required	Required
Parent / Legally Responsible Person's Signature:	Not Required (Obtain whenever possible) <u>If not obtained</u> : Document efforts to get signature, the parent's participation in development and agreement with the plan, and the parent's level of involvement in treatment in Progress Notes	Not Obtained (It is the minor's TP)

Client Signature:

- Minor 12 or older:
 - If a minor age 12 or older is mature enough to participate intelligently in treatment planning, his/her signature on the TP is required. The client's signature helps document the client's participation in creating the TP and agreement with it.

Parent/Legally Responsible Person Signature:

- If the Parent/Legally Responsible Person client is unavailable for signature at the time the TP is developed:
 - ✓ Document the agreement with and participation in the development of the plan in a Plan Development Progress Note.
 - ✓ Obtain the signature at the next face-to-face visit
 - ✓ If the Parent/Legally Responsible person is not actively involved in treatment with the minor, make reasonable efforts to obtain the parent's signature. Document the results in Progress

Note(s).

Examples of reasonable efforts include at least several attempts of the following:

- Set up home, school or office visits with the parent to obtain signature (preferred)
- Mail a copy to the parent with a stamped return envelope, etc. (less effective)
- Send a copy home with the minor for parent signature (least effective)

✓ Consult with your supervisor

Minor 12 or older:

- Parent/Legally Responsible Person signature on the TP is normally obtained prior to delivering or billing for ongoing services when a minor is 12 or older. There are two exceptions when the minor is mature enough to participate intelligently in treatment planning and has signed the TP as the client:
 - Parent Unavailable for Signature: If the parent previously signed the Consent for Treatment, but is unavailable to sign the TP despite documented, reasonable attempts (see above for examples) take all the following steps:
 - ✓ Discuss the TP with the parent by phone and then document the parent's agreement with and participation in the development of the TP and your attempts to obtain signature in Progress Note(s).
 - ✓ If the parent is unavailable even by phone, document your efforts to involve them in treatment and your attempts to obtain signature in Progress Note(s).
 - ✓ Discuss the absence of the parent signature with your Program Supervisor; document your discussion.
 - ✓ The minor's signature on the TP is sufficient in this limited circumstance.
 - Minor Consent services: The therapist is required to involve the parent in treatment unless the therapist determines that parental involvement is inappropriate. The decision and any efforts to involve the parent must be clearly documented in Progress Notes. If the parental involvement is inappropriate, the Parent/Legally Responsible Person signature is not obtained on either the Consent for Treatment or the TP. Program Supervisor approval is required for Minor Consent services.

Notes:

¹Minor consent is limited to outpatient services and excludes psychotropic medication, ECT or psychosurgery.

²When a minor could have consented for his or her own services, but did not, discuss the risks and benefits of treatment with the minor and the parent and then obtain both the minor's and the Parent's/Legally Responsible Person's signature on the Consent for Treatment and TP.

³When minor consents for their own services, the record must document:

- An explicit statement that the professional person believes the minor is mature enough to participate intelligently in outpatient services. (*Family Code § 6924 and Health & Safety Code § 124260*)
- A statement that the minor would present a danger of serious physical or mental harm to self or others without the mental health treatment, or is the alleged victim of incest or child abuse. Services can only be billed to Medi-Cal if the minor meets the stricter *Family Code § 6924* requirements and has Minor Consent Medi-Cal. (*Family Code § 6924 / Minor Consent Medi-Cal services only; not applicable to Health & Safety Code § 124260 services*)
- The attempts to involve the parent and the outcome of the attempts, or the reasons why the provider thinks it would be inappropriate to involve the parent in the minor's treatment. (*Family Code § 6924 and Health & Safety Code § 124260*)

⁴When a minor consents (or could have consented) for his or her own services, the minor controls access to the record and must any Release of Information form prior to third party disclosure (excludes mandated reporting and "must" disclosures).

⁵When a minor could have consented for his or her own services, but did not, usually the best choice is to discuss potential third party disclosures with the minor and the parent, and then obtain both the minor's and the Parent's/Legally Responsible Person's signatures on the Release of Information.

⁶When a minor consents for his or her own services, the minor's written release of information is required before disclosing outpatient treatment information to a parent. Involving parents in treatment will necessitate sharing certain otherwise confidential information; however, having them participate does not mean parents have a right to access all confidential records. Providers should honor the minor's right to confidentiality to the extent possible while still involving parents in treatment – disclose the minimum necessary to accomplish the treatment purpose. A separate exception to confidentiality applies to Drug & Alcohol treatment information (42 C.F.R. §2.14).

✧Appendix I: ISL Policy✧

This section is under construction.

✧Appendix J: Service Codes✧

This section is under contruction.

✧Appendix K: Service Indicators✧

Service Indicator	Description	Definition
Person	Who was present (in person or by phone) for the service or who was the service for?	
B	Client with Family	Use 'B' if client is present with family in session.
C	Client	Use 'C' if client was present.
F	Family	Use 'F' if client not present with family. Define 'family' broadly. Includes foster, guardianship, adoption, caregiver or other living situations which the client considers 'family'.
L	Legal Guardian	Use 'L' primarily for other legal representatives, i.e., conservators, court appointed representatives. If family members have legal guardianship and participate in session, choose B or F.
O	Other	Use 'O' if Social Worker, Probation Officer, teacher, etc. were present or if the service was on behalf of a client with nobody present (e.g. Plan Development without a client, report writing, etc.).
S	Other Service Provider	Use 'S' if other BH therapists, Group Home staff, partner agency staff, etc. were present for the service without client.
Place	Select the place where you delivered the service.	
A	Office	Use if your office is at a BH site, including SAFE, etc.
B	Field (unspecified)	Services are provided away from usual place of business. No other more specific choice applies.
C	Correctional Facility	Jail, not JSC. If JSC use 'Y'.
D	Inpatient	PHF or other hospital.
E	Homeless - Emergency Shelter	Use if service was provided at a Homeless Shelter or Emergency Shelter.
F	Faith Based (church)	
G	Health Care - Primary Care	Primary Care MD's office, CHC
H	Home	Client's home. Private residence where client receives services.
I	Age-Specific Comm Center	Senior Center, for example. Comm = Community
J	Client Job Site	
K	Res Care Facility - Aging	
L	Licensed Comm Care Facility	Comm = Community.
M	Mobile Service	We don't currently use this.
N	Non-traditional Service Loctn	River bed, park bench, etc. Will primarily be used by MHSA outreach staff. Loctn = location.

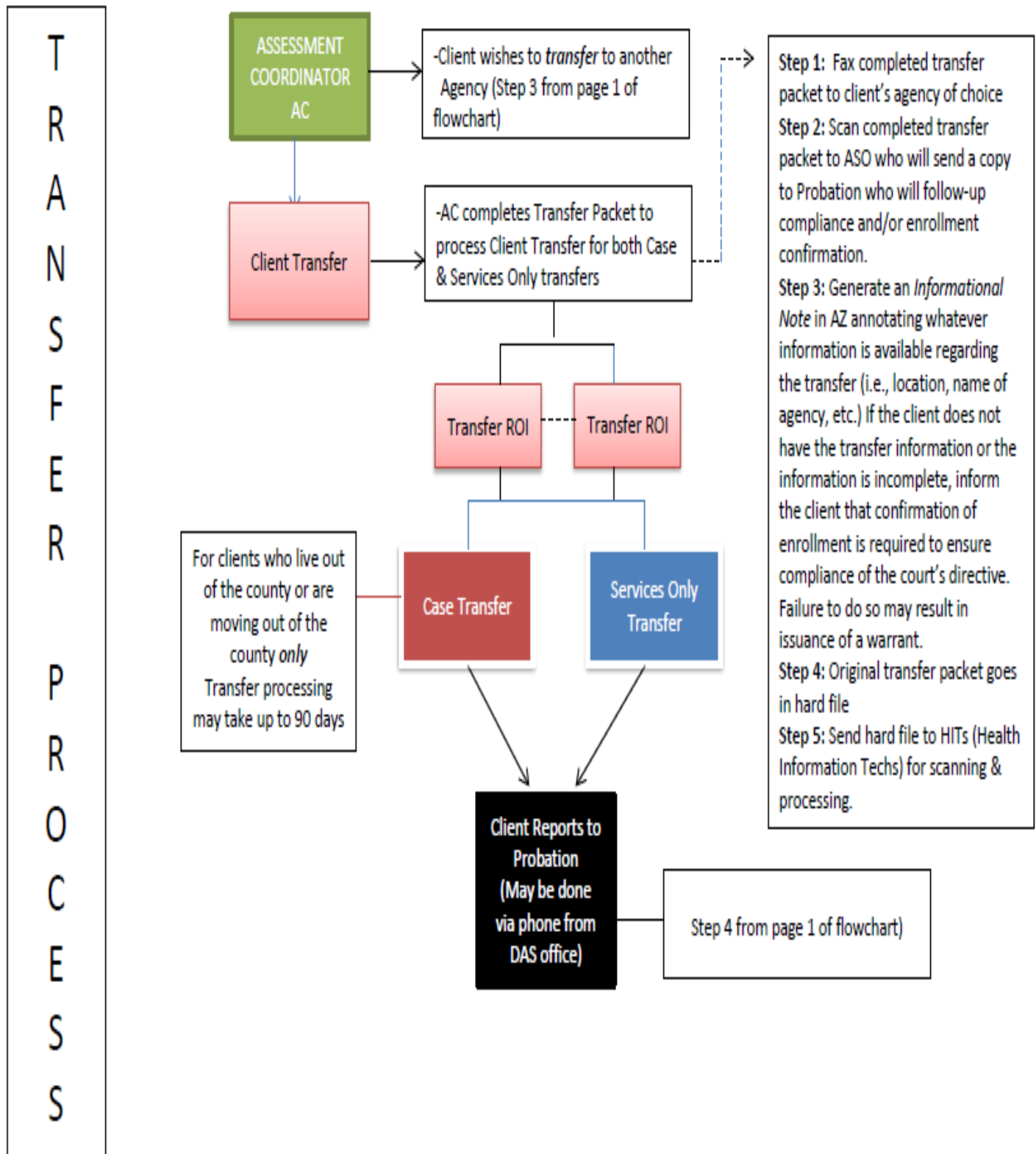
O	Other Community Location	
P	Phone	Use 'P' if service provided by phone, even if in office.
Q	Satellite	DAS uses it for Parole in Santa Maria.
R	Res Care Facility - Children	RCL 13-14
S	School	Use if you deliver services at a school
T	Telehealth	
U	Other	
V	MH Adult Residential	Board & Care, Adult Placement
W	Group Home	RCL 10-12
X	SA Residential	Substance Abuse Residential including Sober Living
Y	Juvenile Center	JSC
Z	Unknown/Not Reported	
Contact Type		
F	Face-to-face	A person (see Person above) is present for the service.
O	Other	Billable consultations, Plan Development, etc. if no client present.
P	Telephone - Spanish	Use if server or interpreter is speaking with a person in Spanish on the phone.
S	Face-to-face - Spanish	Use if server or interpreter is speaking Spanish face-to-face.
T	Telephone	Use if talking with a person in English on the phone. Billable if a service was provided, not billable if purely clerical.
V	Voice Mail	Use if listening to or leaving a message (English or Spanish). Not billable.
Y	TTY	Communication device for hearing impaired clients.
Appointment Type		
1	Scheduled	Scheduled = planned, broadly defined. Include, but don't limit to, appointments set for a specific time of day. Clients served at a site on a regularly scheduled day are scheduled, even if appointments have no set time.
2	Unscheduled/Walk-in	Walk-Ins, walk in screenings, unscheduled phone calls, etc.
5	No Show	Client is charged for DAS.
6	Refused Drug Test	DAS value – charged.
7	Excused Absence	DAS value – no charge.
Billing Types		
S	Standard Service	All regular, planned services or services which don't require a plan (Assessment, Crisis, Plan Development).
Intensity Types		
C	Crisis: Within 1 hour	Use only with Crisis Intervention. Response time is within 1 hr. of the client's call in or walk in request for services.

D	Crisis: Same Day	Use only with Crisis Intervention. Use if the crisis service is provided on the same day but more than 1 hour after the client's request.
U	Urgent: Within 7 Days	Use with any service other than Crisis Intervention. Not an emergency, but client needs to be seen sooner than their normal schedule. Clients who walk in and insist on being seen immediately are coded as Urgent if not in crisis. Days are calendar days.
V	Urgent: 8-14 Days	
R	Routine	<u>Client's</u> regular appointment schedule, not limited to weekly, etc.

✧Appendix L: Documentation for Specialty Treatment Programs ✧

This section is under construction.

✧Appendix M: Prop 36 Transfer Process Diagram✧



✧Appendix N: Transfer Policy & Procedure✧

This section is under construction.

✧Appendix O: Holman Referrals✧

Referral Process (Effective 12/15/2014)

When SAT determines that a Medi-Cal client does not meet medical necessity for SMHS and that the client will be referred to the Holman Group, the Program Supervisor (MC PS) will assign a clinician to inform the client of this determination and complete the referral procedure. If the client was receiving SMHS but is ready to step down to the Holman Group, the assigned clinician will usually be the SAI.

The assigned clinician discusses the referral with the client by phone or in person.

The assigned clinician completes both tabs of the “MH Referral to CenCal Health/Holman Group” assessment in Anasazi. It is important to complete the referral fully to clearly communicate the findings of the SAT and to facilitate the acceptance of the referral. Some information will pull forward into the referral, but it must be reviewed and edited as needed.

- Tab 1 contains demographic and general information about the referral
- Tab 2 imports risk factor ratings (adults only) and impairment ratings from the Assessment

Disclosure of PHI in the course of providing a referral must be logged (W&I Code 5328.6). The assigned clinician will:

- Launch the BH Record of Disclosure in Anasazi
- Enter “Holman Group” in the “Disclosed To” section
- Enter “Holman Referral dated xx/xx/14” in the “Description of Information Disclosed” section
- Enter “Referral to Holman Group” in the “Purpose of Disclosure” section
- Sign the BH Record of Disclosure as the Clinician **(Delete the LPHA signature line)**
- Route the BH Record of Disclosure to the HIT (enter the HIT’s name in the Staff Disclosing Information signature line).

Complete an NOA A, which the HIT will mail to the client. Note: An NOA A is only needed if SMHS are being denied after the initial comprehensive assessment, not for referrals of stable clients who are stepping down.

The HIT will:

- Finish and Final Approve the BH Record of Disclosure
- Route the MH Referral to CenCal Health/Holman Group to the MC PS
- Fax the referral and a current MEDS screen to the Holman Group
- **Final Approve and mail the NOA A**

The MC PS will contact the Holman Group to confirm that they have accepted responsibility for providing services (W&I Code 5008 (d)). Once confirmation has been received, the MC PS will final approve the MH Referral to CenCal Health/Holman Group and inform the referring clinic’s HIT that the case may be closed.

If the client was receiving SMHS and is stepping down to Holman Group, the assigned clinician will complete a MH Outpatient Discharge Summary in Anasazi.

If the MC PS is unable to confirm that the Holman Group has accepted the referral within 30 days of the referral, or if the Holman Group does not accept the case, the MC PS will contact the referring clinician and/or the Program Supervisor to discuss the needs of the client. Staff will re-evaluate whether SMHS will be offered/continued, if other referrals are needed, or if the Problem Resolution process will be utilized on behalf of the client.

The MC PS will initiate the Problem Resolution process jointly developed by Behavioral Health, CenCal Health and the Holman Group if needed, and will coordinate with the clinic site Program Supervisor. The client's case will remain open at the clinic site during the time needed to verify that the referral was accepted and during the Problem Resolution process (if utilized).

✧Appendix P: Medication Refill Workflow Diagram✧

This section is under construction.

✧Appendix Q: Sample Treatment Plan✧

Name: SA CLIENT, FICTIONAL 03
Type: SA Treatment Plan
Printed on 01/17/2017 at 04:52 PM

Case#: 400013

Page: 1 of 4
Date: 01/13/2017 - 04/12/2017
(Draft)

Treatment Plan

Level	Type	Description	Status	Established Date	Target Date	Status Date
1	Strength	Accepts Feedback from Others <i>Maryanne accepts feedback from others and she states this will help her during group treatment services.</i>	Active	01/13/2017		01/13/2017
2	Strength	Hobbies <i>Maryanne has multiple hobbies which will help her navigate unstructured time.</i>	Active	01/13/2017		01/13/2017
3	Strength	Resilient <i>Maryanne states that she is resilient and that this will help her accomplish her treatment goals.</i>	Active	01/13/2017		01/13/2017
1	Focus of Treatment	Substance Related Problems <i>Maryanne states that her substance use disorder has caused the following barriers: interfered with the ability to maintain employment, healthy relationships with family and friends, and care of her health.</i> <i>Maryanne's primary Counselor/Therapist/SAI (Julianne Schmidt) will be working with client in treatment to obtain goals.</i>	Active	01/13/2017	04/12/2017	01/13/2017
1.1	Goal	Increase Freedom from Substance Use Problems <i>Maryanne will increase freedom from substance use problems as evident by no new health issues as a result of using, maintaining sober relationships, and increased ability to care for self.</i>	Active	01/13/2017	04/12/2017	01/13/2017
1.1.1	Objective	Develop/Use Recovery Plan <i>Maryanne will develop and use a recovery plan to learn about people, places, and things that cause internal and external triggers for substance use, to develop a sober support system, and to schedule structured time to attend to her healthcare needs and other tasks necessary to live a healthy, balanced life.</i>	Active	01/13/2017	04/12/2017	01/13/2017
1.1.1.1	Intervention	SA Individual Counseling Frequency: Every two weeks Duration: 1:00 <i>Staff will provide Individual Counseling as needed to discuss issues related to cravings, triggers, recovery planning, and family of origin issues as it relates to prevention from relapse.</i>	Active	01/13/2017		01/13/2017
1.1.1.2	Intervention	SA Tx Plan Development Frequency: Quarterly Duration: 1:00 <i>Staff will work with Maryanne on developing a treatment plan to establish treatment goals, objectives, and action steps. Staff will meet with Maryanne every 90 days to monitor goals met and develop new goals as treatment progresses.</i>	Active	01/13/2017		01/13/2017
1.1.2	Objective	Adhere to Alcohol/Drug Testing Protocols <i>Maryanne will participate in randomized alcohol/drug screenings and will feel a sense of accomplishment by having clean tests. Maryanne is on test color red which randomly tests a minimum of two times per month in order to comply with treatment program and show proof of sober behaviors.</i>	Active	01/13/2017	04/12/2017	01/13/2017
1.1.2.1	Intervention	SA DT UA Dip Test Frequency: Ad Hoc <i>DAS Staff will provide dip testing randomly during treatment services.</i>	Active	01/13/2017		01/13/2017
1.1.2.2	Intervention	SA DT Urinalysis Frequency: Ad Hoc <i>DAS Staff will provide UA testing randomly during treatment services.</i>	Active	01/13/2017		01/13/2017

Treatment Plan

Level	Type	Description	Status	Established Date	Target Date	Status Date
1.1.3	Objective	Improve Personal Health <i>Maryanne will work on improving physical health status to support successful recovery from drug/alcohol use by:</i> 1. Obtain a physical (if not obtained in the last 12 months) and repeat each year. 2. Care for her physical health issues by following primary care physician's recommendations. 3. Improve healthy living by eating well, exercising, sleeping/resting, and abstaining from drugs and alcohol. 4. Keep medical and/or dental appointments more often as needed to treat any current medical conditions.	Active	01/13/2017	04/14/2017	01/13/2017
1.1.3.1	Intervention	SA Care Management Frequency: Ad Hoc <i>Staff will provide care management to support Maryanne's efforts in connecting to physical health care providers and following through with medical related tasks.</i>	Active	01/13/2017		01/13/2017

✧Appendix R: Sample Progress Notes✧

EXAMPLE OF A SCREENING PROGRESS NOTE:

FOCUS OF SESSION:

SUD Screening

CLINICAL DECISIONS AND INTERVENTIONS:

(Describe your specific, individualized interventions or decisions aimed at reducing the impairment. If you taught a coping skill or a recovery tool, monitored progress or developed a plan, describe what you did here):

Clinician completed walk-in screening: See BH Initial Screening and Diagnostic Review dated xx/xx/xx for detail.

Specialist scheduled client for assessment appointment.

Therapist provided a referral for the client to MH for MH assessment.

Therapist provided client with to brochure on Naloxone and scheduled client appointment with LPT for Naloxone training.

CLIENT'S RESPONSE:

(Describe how the client/family responded to your intervention(s)).

Client actively participated in the SUD Screening Session.

Client did not appear to be forthcoming with information related to their substance use.

Client agreed that Clinician could collaborate with her MH Therapist and signed a ROI.

DESCRIBE PROGRESS TO PLAN:

Client meets medical necessity for SUD treatment services and will attend an assessment appointment.

EXAMPLE OF AN ASSESSMENT PROGRESS NOTE:

FOCUS OF SESSION:

SUD Assessment

CLINICAL DECISIONS AND INTERVENTIONS:

(Describe your specific, individualized interventions or decisions aimed at reducing the impairment. If you taught a coping skill or a recovery tool, monitored progress or developed a plan, describe what you did here):

Therapist completed Assessment: See SUD Assessment dated xx/xx/xx for detail.

CLIENT'S RESPONSE:

(Describe how the client/family responded to your intervention(s)).

Client appeared forthcoming with reports of withdrawal, medical issues, and emotional issues.

DESCRIBE PROGRESS TO PLAN:

Client will start treatment groups on xx/xx/xx and will have a case management appointment for SLE housing on xx/xx/xx.

EXAMPLE OF A PLAN DEVELOPMENT PROGRESS NOTE:

FOCUS OF SESSION:

Plan Development Individual Service

Created an individualized Treatment Plan with client.

CLINICAL DECISIONS AND INTERVENTIONS:

(Describe your specific, individualized interventions or decisions aimed at reducing the impairment. If you taught a coping skill or a recovery tool, monitored progress or developed a plan, describe what you did here):

Specialist assisted client in identifying his strengths that will aid him in treatment.

Specialist engaged client in discussion about goals and objectives for treatment as it relates to their substance use disorder.

Specialist developed treatment goals and objectives with client.

Specialist reviewed treatment plan goals and objectives, noting updates and progress/regression at this 90 day treatment plan review.

CLIENT'S RESPONSE:

(Describe how the client/family responded to your intervention(s)).

Client was able to identify several strengths that he can utilize to meet his goals.

Client identified 2 areas of functioning that he would like to improve.

Client actively participated in the development of his treatment goals and objectives.

Client was able to acknowledge the progress he has made toward his treatment goals and objectives in the first 90 days of treatment.

Client agrees with the current TP.

DESCRIBE PROGRESS TO PLAN:

Client has completed his first 30 days in treatment with good attendance and negative drug testing.

Client and Therapists will review the client's treatment plan in 90 days to monitor progress/regression, re-establish medically necessity and confirm client is placed in the correct level of care for her needs.

EXAMPLE OF A CRISIS PROGRESS NOTE:**FOCUS OF SESSION:**

Crisis Individual Service

Client reported that she felt highly triggered to use alcohol today due to a fight with her mother.

Client reported that he had thoughts about wanting to cut himself related to his recent relapse.

CLINICAL DECISIONS AND INTERVENTIONS:

(Describe your specific, individualized interventions or decisions aimed at reducing the impairment. If you taught a coping skill or a recovery tool, monitored progress or developed a plan, describe what you did here):

Specialist actively listened to client and provided supportive feedback as the client processed their substance use disorder crisis.

Specialist engaged client in an inventory of their supports and a plan to avoid relapse, including scheduling and planning phone calls until next scheduled treatment service.

Specialist reviewed the client's relapse prevention plan, making changes so that the client would be less likely to relapse when experiencing internal and external triggers.

Specialist referred the client to MAT Services to address cravings that cause relapse after short periods of sobriety.

Specialist engaged client in an evaluation of their relapse in order to avoid further use/relapse. Specialist assessed for suicide risk based upon client's statement "I want to give up – maybe I will overdose" (i.e. access to means, history of suicidal gestures or attempts, current plan, and proximity of support system). Specialist contacted Mobile Crisis to evaluate client as their relapse/use over the last 3 days has included thoughts and plan for suicide. Specialist completed a safety plan; reviewing crisis phone numbers that client can access 24/7 should thoughts about suicide return.

CLIENT'S RESPONSE:

(Describe how the client/family responded to your intervention(s).

Client clearly identified the internal and external triggers that were putting him at increased risk of relapse. Client completed a relapse prevention plan during the crisis session, and placed a call to his sponsor to discuss the plan for this evening.

Client agreed to attend a social support meeting tonight (NA) and to meet with Specialist prior to group tomorrow morning to check-in.

Client agreed to call Specialist at 4:00pm today for check-in.

Client denied current plan for self-harm, and agreed to remain sober tonight to reduce the likelihood of continued self-harm thoughts. Client contracted for safety and agreed to attend scheduled MH assessment appointment.

DESCRIBE PROGRESS TO PLAN:

Client made progress during this crisis session as evidenced by identifying the increased social support she has developed in her recovery network that she would utilize to avoid using today.

Client was aware of community resources (crisis phone numbers) and identified progress he has made in treatment to avoid people, places, and things that cause triggers. Client will employ this learning tonight by avoiding a part of the city that causes triggers.

EXAMPLE OF A COLLATERAL PROGRESS NOTE:

FOCUS OF SESSION:

Collateral Service with client and her sponsor.

Collateral Service with client and his wife.

CLINICAL DECISIONS AND INTERVENTIONS:

(Describe your specific, individualized interventions or decisions aimed at reducing the impairment. If you taught a coping skill or a recovery tool, monitored progress or developed a plan, describe what you did here):

Specialist encouraged client to share his external trigger list with his wife to support the client's recovery environment.

With permission from the client, Specialist reviewed the client's treatment plan with client and her sponsor to gain additional collaboration around client's goals.

Specialist assisted client and support person in developing a list of appointments to schedule to support the client's overall wellness (dentist, physical).

CLIENT'S RESPONSE / PROGRESS IN TREATMENT:

(Describe how the client/family responded to your intervention(s). Describe client's progress toward his/her objective[s]):

Client appeared comfortable with telling his wife that her occasional alcohol consumption at home makes him feel anxious.

Client and sponsor agreed upon their step work schedule during the session.

DESCRIBE PLAN / REFERRALS / FOLLOW-UP CARE NEEDED:

Client made progress today as evidenced by sharing 2 treatment goals with his significant other, thus increasing his social support.

After hearing his wife express concerns about the client's health, client agreed to make an appointment for a physical by the end of the day tomorrow.

EXAMPLE OF AN INDIVIDUAL COUNSELING PROGRESS NOTE:

FOCUS OF SESSION:

Individual Counseling

CLINICAL DECISIONS AND INTERVENTIONS:

(Describe your specific, individualized interventions or decisions aimed at reducing the impairment. If you taught a coping skill or a recovery tool, monitored progress or developed a plan, describe what you did here):

Specialist and client rehearsed "I statements" that client will use in social settings to maintain sober behaviors. Specialist encouraged client to explore fears related to obtaining a physical.

Specialist provided the client with a relapse prevention plan and assisted client with the completion of her plan.

Specialist assessed for risk factors and ruled out mandatory reporting obligations at this time.

CLIENT'S RESPONSE:

(Describe how the client/family responded to your intervention(s). Describe client's progress toward his/her objective[s]):

Client described his anxiety related to his return to court tomorrow.

Client identified two events he wants to take his children to in the next month in order to engage the family in fun sober activities.

Client processed feelings of guilt that coincide with periods of substance use in the past.

PROGRESS TO PLAN:

Client identified 1 new coping skill (knitting) to manage feelings of boredom.

Client completed his physical examination which demonstrates progress towards the client's goal of increasing his attention towards his physical health.

EXAMPLE OF A GROUP COUNSELING PROGRESS NOTE:

Overview Progress Note Section

FOCUS OF SESSION:

Group Matrix: Scheduling

Seeking Safety: Safety

Group Counseling: I-Statements in social settings

CLINICAL DECISIONS AND INTERVENTIONS:

Specialist facilitated a breathing exercise to ground session and bring focus to the group.

Specialist led group members in a social skills activity using "I Statements," and Therapist facilitated discussion about the importance of assertive communication.

Specialist provided scheduling materials and monitored the group of clients for any needs with scheduling assistance. Therapist provided an example schedule to model how one must structure their time to reduce likelihood of relapse.

Client Progress Note Section

CLIENT'S RESPONSE:

(Describe how the client/family responded to your intervention(s). Describe client's progress toward his/her objective[s]):

Client actively participated in group discussion. Client was able to identify three I-Statements that he could utilize while in unexpected social settings where alcohol is being consumed.

Client identified holes in his structure/schedule which could lead to boredom and potential increased thoughts of using.

Client acknowledged that the deep breathing exercise is difficult for him to do in a social setting and planned to practice 2 x at home this week.

PROGRESS TO PLAN:

Client has improved upon his attendance this week to treatment, attending all 4 treatment services and 1 drug screening.

Client has reduced his treatment service by 1 group as she completed Matrix Early Recovery groups last week.

Client has demonstrated poor attendance and had a positive drug test yesterday for THC. Specialist has scheduled an individual session to occur tomorrow.

EXAMPLE OF A CASE MANAGEMENT PROGRESS NOTE:

FOCUS OF SESSION: Domain/life area being addressed.

Care/Case Management Individual Service focused on the client's needs for SLE placement.

Care/Case Management Individual Service focused on employment to increase client's structured time.

CLINICAL DECISIONS AND INTERVENTIONS: Action that occurred. Assisting client to identify or achieve client needs.

Rehearsed phone calls with client to SLE/Residential Treatment providers.

Provided client with a list of resources for xyz.

Scheduled client for Naloxone education with LPT.

OUTCOME: Follow through on intervention.

Client followed through on contacting 5 SLE's, and located that 1 SLE had an opening.

Client is scheduled for Naloxone training on xx/xx/xxxx.

✧Appendix S: Sample Medical/Nursing Progress Notes✧

This section is under construction.